S. HRG. 101-810

HOME HEALTH CARE FOR THE ELDERLY IN MISSISSIPPI

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

EXAMINING THE DELIVERY OF HOME HEALTH CARE SERVICES TO THE OLDER CITIZENS IN THE STATE OF MISSISSIPPI

FEBRUARY 15, 1990
MERIDIAN, MS

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE
28-480 ⇆ WASHINGTON : 1990

For sale by Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S541-39

COMMITTEE ON LABOR AND HUMAN RESOURCES

EDWARD M. KENNEDY, Massachusetts, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
SPARK M. MATSUNAGA, Hawaii
CHRISTOPHER J. DODD, Connecticut
PAUL SIMON, Illinois
TOM HARKIN, Iowa
BROCK ADAMS, Washington
BARBARA A. MIKULSKI, Maryland

ORRIN G. HATCH, Utah
NANCY LANDON KASSEBAUM, Kansas
JIM JEFFORDS, Vermont
DAN COATS, Indiana
STROM THURMOND, South Carolina
DAVE DURENBERGER, Minnesota
THAD COCHRAN, Mississippi

NICK LITTLEFIELD, *Staff Director and Chief Counsel*
KRISTINE A. IVERSON, *Minority Staff Director*

SUBCOMMITTEE ON AGING

SPARK M. MATSUNAGA, Hawaii, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
CHRISTOPHER J. DODD, Connecticut
EDWARD M. KENNEDY, Massachusetts

THAD COCHRAN, Mississippi
DAVE DURENBERGER, Minnesota
DAN COATS, Indiana
ORRIN G. HATCH, Utah
(Ex Officio)

ELMA HENDERSON, *Professional Staff Member*
JAMES H. LOFTON, *Minority Staff Director*

CONTENTS

Page

Marshall, Billie, interim director, Council on Aging, Mississippi Department of Human Services, Jackson, MS; accompanied by Eddie Anderson, deputy director for the Council on Aging 3
  Prepared statement 5
Gager, Martiel, Chunky, MS; and Alberta Johnson, Philadelphia, MS 12
McIntyre, Helen, R.N., director, Riley Home Health Services, Inc., Meridian, MS; Jane Kennedy, director, southern Mississippi Area Agency on Aging, Gulfport, MS; Dave Beck, district administrator, District IV, Mississippi State Department of Health, Starkville, MS; and Mike Greenhill, representative, Mississippi Association of Health Underwriters, Jackson, MS 16
  Prepared statements of:
    Ms McIntyre 20
    Ms. Kennedy 31
Covington, Dr. Joe, internist, Meridian, MS; Mary Stainton, R.N., vice president/director of nursing, South Mississippi Home Health, Hattiesburg, MS; Dr. Jerald Jackson, internist, Hattiesburg, MS; and Kathy Lomax, R.N., director of nurses, Quality Home Health, Biloxi, MS 49
  Prepared statements of:
    Dr. Covington 52
    Ms. Stainton 60
    Dr. Jackson 74
    Ms. Lomax 79
Diaz, John, regional program director, region VI, Administration on Aging, Dallas, TX; and Ronald Niswander, deputy regional administrator, region VI, Health Care Financing Administration, Atlanta, GA 87
  Prepared statement 90
Statewide Healthcare Services, Inc., Patrick F. Yarborough, president, prepared statement 106

HOME HEALTH CARE FOR THE ELDERLY IN MISSISSIPPI

THURSDAY, FEBRUARY 15, 1990

U.S. SENATE,
SUBCOMMITTEE ON AGING
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Meridian, MS

The subcommittee met, pursuant to notice, at 9:00 a.m., in the auditorium of the East Mississippi Electric Power Association, Meridian, MS, Senator Thad Cochran, presiding.

Present: Senator Cochran.

Senator COCHRAN. The hearing of the Subcommittee on Aging of the U.S. Senate Committee on Labor and Human Resources will come to order.

We are very happy to convene this hearing under the auspices of the Subcommittee on Aging of the U.S. Senate here in Meridian, MS. We do so with the approval of the chairman of our subcommittee, Senator Spark Matsunaga of the State of Hawaii.

We have a series of panels of witnesses who will be testifying before our committee today. But before we proceed with our panel's testimony, I want to recognize the presence of my good friend, United States Congressman G.V. Sonny Montgomery, who is here with us today.

Sonny, welcome. We are very happy to be in your congressional district, and I want to invite you to come forward and say anything you would like to say at this point, if you would care to. We appreciate your being here.

Congressman MONTGOMERY. I'll be very brief. We are very pleased Chairman Cochran, that you would come to east Mississippi, our home town, and have this very, very important hearing.

As you and I both know, some of our major problems are with the elderly, especially in home health care.

Thank you very much, Thad, for being here and having this official, historic hearing in this part of our State. I think this is the first time we have ever had a hearing like this. Thank you, sir.

OPENING STATEMENT OF SENATOR COCHRAN

Senator COCHRAN. Thank you very much, Sonny. We appreciate your assistance with these issues, too. Congressman Montgomery, of course, has been in the U.S. House of Representatives since his election in 1966. He has rendered very valuable and important service to our State and to our Nation since that time as a member of our State's Congressional Delegation. It has been a real pleasure to serve with him and work with him over the years, both as a Member of the House and then later as a Member of the U.S. Senate.

Let me just say a few things at the outset about the issues that we are interested in pursuing today and why we are here and why we are taking the time to get the opinions and the suggestions from those who will be testifying before the committee today.

We are going to be looking at the delivery of home health care services, specifically to the older citizens in our population in the State of Mississippi. In October of 1988, I was pleased to chair a similar hearing in Tupelo, MS, on elderly health care. We received some very helpful and good suggestions, thoughtful testimony on the problems facing our health care delivery system in meeting the needs of a growing population of elderly citizens.

These field hearings and hearings that have been held and will be held in Washington, will assist our committee when it considers the reauthorization of the Older Americans Act next year. The increasing cost of health care in recent years and the aging of our population compel us to find more cost effective and efficient means of delivering quality health care to the elderly.

Today's hearing will contribute to the national debate on comprehensive long-term health care for the elderly. That is almost an incidental contribution, but it is a very important one. Home health care services that will enable more of our elderly to avoid institutional care must be a major component of any strategy designed to deal with comprehensive long-term care.

Home health care is, in many cases, less expensive than institutional care and is preferred, of course, by most. We need to look at a variety of options and alternatives where home health care is more appropriate for the family and more cost effective for everyone concerned.

The witnesses at today's hearing can provide our subcommittee with a better understanding of the home care option for delivering health care services. We will hear directly from those who have first-hand knowledge and experiences that we can learn from. We will also hear from those who are familiar with the operation of the Federal and State programs designed to support their efforts.

Specifically, we will hear from families where home health care services have been helpful, from people who are involved in providing home health care services, either directly or indirectly, and we will also hear from medical professionals who will provide their insights and recommendations to the committee. Representatives of two Federal agencies will describe the Federal programs in this issue area and answer questions that we have regarding the programs that may arise during the course of the hearing.

We want to welcome as our first witness and first panel Mrs. Billy Marshall, who is representing the Mississippi Council on Aging. She will provide us with information on the elderly situation in Mississippi and an overview based on her experiences that she has gained over a period of time working in this area.

She is Interim Director of the Council on Aging. She is accompanied this morning by Mr. Eddie Anderson, Deputy Director of the Mississippi Council on Aging. We welcome you and thank you for being here to help lead off our hearing today in Meridian. Mrs. Marshall.

STATEMENT OF BILLIE MARSHALL, INTERIM DIRECTOR, COUNCIL ON AGING, MISSISSIPPI DEPARTMENT OF HUMAN SERVICES, JACKSON, MS; ACCOMPANIED BY EDDIE ANDERSON, DEPUTY DIRECTOR FOR THE COUNCIL ON AGING

Mrs. Marshall. Thank you so much for the opportunity to share our concerns about home health care for the elderly in Mississippi. As you said, Eddie Anderson, who is the Assistant Director for the Council on Aging, will assist me in answering any questions that you may have about our testimony.

I'm going to center my comments generally on four basic issues. Of course, you have the entire testimony before you. But the four issues that I want to emphasize are the current status of issues facing older persons in our State, efforts implemented by the aging network to address these issues, projected needs for the elderly into the next century, and recommendations that we would like to make for consideration in addressing these needs.

Current statistics indicate that Mississippi has a 60-plus population of approximately 425,000 older persons. Since 1970 this population has grown steadily. By the year 2010, it is expected to reach approximately one-half million.

As you are aware, three basic categories have been identified with the elderly population—that being the young-old, the middle-old, and the old-old.

The old-old population, which we characterized as 75 and older, have had the largest and most rapid growth rates, and it will continue into the middle of the next century. The old-old population tends to require more social and medical supportive services.

In 1985, the Council on Aging conducted a statewide needs assessment to identify the concerns and needs of older persons in the State. We needed to know this information in order to plan for future directions of the council and the aging network in our State.

One of the most enlightening, but not surprising, indications of the survey was that most of the older people that were surveyed wanted to retain a sufficient level of independence and self-care management, and wanted to be allowed to remain in their own homes and own communities. I'm sure these were found to be true across the State lines.

And the growing population of the elderly coupled with a desire to remain in the community presents major challenges, not only to our State unit on aging, but also for human services policymakers and planners across the Nation.

The Council on Aging recognizes that home and community based programs are the most viable, economical, and cost effective means of utilizing limited funds to assist older adults.

The Council on Aging implemented a Community Based Long-Term Care Program in 1985. The need for this coordinated system arose from several factors: One, the high cost of institutional care; two, the preference of older individuals and their caretakers to avoid and delay institutionalization; three, the fragmentation of services and reimbursement policies in entitlement and insurance programs which encourages institutional care often rather than home care; and, fourth, the need for centralized applications, intakes, and referral procedures into the service system.

Since its inception, the Council on Aging has noted that one of the critical services needed by the clients in the case management community based long-term care system is home health care.

Currently our case management program has enrolled over 2,100 clients with approximately 315 clients on a waiting list. The number receiving home health services is approximately 659. These services are financed through various sources including Medicare, Medicaid, and, to a limit degree, by the Older Americans Act, and Social Services Block Grant funds.

According to the 1989 State Department of Health Plan, there are 26 regional Home Health Agencies operated by its offices in 82 Mississippi counties. Also, 20 hospital based and 32 free-standing home health agencies operate in the State. It is our observation that the services are generally available in most areas.

The major problem, however, rests with access to the service. Access to the service is limited, to a large degree, to Medicaid and Medicaid eligibility. Another problem is level of care implications under these programs. Both of these problems are compounded by the prospective payment system for hospitals whereby often patients are released earlier and sicker.

Thus it is the opinion of the Council on Aging that the scope and range of home health services in Mississippi is inadequate to meet the needs of the state's elderly citizens.

In order to address these inadequacies, the Council would suggest to the committee the following items: One, that legislation be changed to allow in-home services to become, without waiver, allowable along with the present array of services funded by Medicaid, or that guidelines be streamlined to make expansion of the 2176 Waiver program less restrictive.

Two, that a larger share of the Federal financing mechanism be directed toward in-home care as an alternative to institutional care.

Three, that the Health Care Finance Administration recognize the Administration on Aging's network as the focal and entry point for older persons to access needed in-home care, and that this network be sanctioned for case management of these clients.

Four, that hospitals and/or physicians be required to have a community health care management plan in place to address patient discharge needs thereby curtailing the negative impact of DRG's on older citizens.

Five, that the eligibility and level of care requirements of home health services under Medicare and Medicaid be reviewed and altered to remove present barriers and access to care.

And, six, that the National Association on Aging's Federal Long Term Care Reform Proposal be given full consideration in future discussions on the long-term care reform.

Again, thank you for the opportunity to participate in this forum and to make these comments, and to have our testimony presented to the entire committee. And Eddie and I would be happy to answer any questions that you might have at this time.

[The prepared statement of Ms. Marshall follows:]

PREPARED STATEMENT OF BILLIE MARSHALL

Thank you for this opportunity to appear before you this morning to share the Mississippi Council on Aging's concerns about home health care for the elderly in our state. The Council shares the national concern with the availability and access to home care for all senior citizens.

The continued growth of this population has signaled major changes in the way human service delivery systems will operate for the coming decades. The population over age sixty grew twice as fast as the rest of the population in the last two decades. The old-old population, those persons age seventy-five and over, increased at an even greater rate. It is anticipated that this population group will continue its rapid growth rate into the middle of the next century. The old-old population tends to require more social and medical supportive services.

In essence, these older persons tend to be the most long-term care dependent. This adds credence to the rising need for long term care services and programs for the elderly.

According to the U.S. Bureau of the Census, Mississippi ranks thirty-two among states when considering the population sixty and over. Current statistics indicate that Mississippi has a 60 plus age population of 425,000. This represents 16% of the state's population. Since 1970 the percentage of older Mississippians has grown by 34 percent, and the number of persons has increased by 106,000. By the year 2010, an 18 percent increase is expected. This growth rate is anticipated to be surpassed by that of the old-old population who are most likely to suffer from chronic health conditions which leave them unable to perform activities of daily living without others'assistance. Currently, there are 138,000 Mississippians in the age category, representing five percent of the state's population. It is anticipated that this figure will grow to 196,000 by 2020, representing a 183 percent increase in the 1970 - 2020 period. By the turn of the century, two of every eleven Mississippians will be 60 plus, and one of every 22 will have reached age 75. Like much of the nation, these populations will place growing demands upon the long-term care service market. The implication of these projections present major challenges for human services policy makers and planners.

In an effort to plan for future directions to meet the needs of Mississippi's aging population, the Council on Aging in 1985 conducted a statewide needs assessment to identify concerns and needs of older people in the State. The average age of respondents was 73. The COA Needs Assessment, revealed that:

* 13% reported their health as poor, and 43% reported only "fair" health.
* 59% of older minorities report their health as fair to poor.
* 9% were unable to see a doctor when needed.
* 19% perceived their health as a major or serious problem.
* 15% could not prepare their own meals.
* 28% could not climb stairs.
* 11% rarely saw a doctor.
* 17% could not cut their own toenails.
* 27% were on some type of special diet.
* Over 35% had spent between 2 days and 2 weeks in the hospital in the last two years.
* Almost 80% took prescription medicines at least once a day or almost every day.

The assessment further indicates that a majority of elderly persons wish to retain a sufficient level of independence and self-care management which would allow them to remain in their own homes and communities.

The elderly, like many age groups, have varied interests, values and needs. In addressing these issues, the Council on Aging recognizes that home and community based programs are the most viable, economical and cost-effective means of utilizing limited funds to assist older adults.

The Council on Aging implemented a Community Based Long Term Care Program in 1985. The need for this coordinated system arose from several factors:

- The high cost of institutional care;
- The preference of elders and their caregivers to avoid and delay institutionalization;
- The fragmentation of services and reimbursement policies in entitlement and insurance programs which encourage institutional rather than home care; and
- The need for centralized applications, intakes and referral procedures into the service system.

It is noteworthy that most of the service priority responses to the Council on Aging's 1985 Needs Assessment speak to maintaining financial and physical independence and sustenance in the most preferred environment - the home and community.

Since its inception the Council on Aging's case management driven community based long term care system has noted that one of the critical services needed by its clients is home health. The home health services provided include nurse visits, physical therapy, speech therapy, home health aid visits and durable medical equipment. The other formal services provided are homemaker, adult day care, respite, home delivered meals and transportation. Social workers provide the case management service and in some cases nurses participate in the team effort.

The program is operating in ten planning and service areas. It is financed by the Older Americans Act, Social Services Block Grant and Medicaid. The component financed by the Medicaid 2176 Waiver Home and Community Based Service program is presently only available in four of the ten PSAs. The Council is continuing to work with the Medicaid office to expand into the other areas.

During FY 1989 the system case managed 2555 clients. The system has enrolled 2100 clients through December of this fiscal year. There are 315 clients on waiting lists for case management services and many others that have not been assessed because service availability is virtually non-existent in the near future.

Case management clients receiving home health services total 659. These services are being financed through various sources including Medicare, Medicaid and to a limited degree by the Older Americans Act and the Social Services Block Grant. A considerable number of the case management clients are in need of the service but are not receiving the service.

According to the 1989 State Department of Health Plan there are 26 regional home health agencies operated by its offices in 82 Mississippi Counties. Also 20 hospital based and 32 free standing home health agencies operate in the State. It is our observation that the services are generally available in most areas. The major problem rests with access to the service. Access to the service is limited, to a large degree, to Medicaid and Medicaid eligibility. Another problem is level of care limitations under those programs. Both these problems are compounded by the prospective payment system for hospitals whereby patients are being released earlier and sicker.

In conclusion it is the opinion of the Council on Aging that the scope and range of home health services in Mississippi is inadequate to meet the needs of the state's elderly citizens.

In order to address these inadequancies the Council would suggest to this committee:

That Legislation be changed to allow in-home services to become, without waiver, allowable along with the present array of services funded by Medicaid or that guidelines be streamlined to make expansion of the 2176 Waiver less restrictive;

That a larger share of the federal financing mechanism be directed toward in-home care as an alternative to institutional care;

That the Health Care Finance Administration recognize the Administration on Aging's network as the focal and entry point for older persons to access needed in-home care and that this network be sanctioned for case management of these clients;

That hospitals and/or physicians be required to have a community health care management plan in place to address patient discharge needs thereby curtailing the negative impact of DRGs on older clients;

That the eligibility and level of care requirements of home health services under Medicare and Medicaid be reviewed and altered to remove present barriers and access to care; and

That the National Association on Aging's Federal Long Term Care Reform Proposal be given full consideration in future discussions on long term care reform.

Again, thank you for the opporutnity to participate in this forum on this critical issue of providing in-home services to older adults.

Senator Cochran. Thank you very much. I appreciate your giving us this overview with the information about the number of persons in our State who are age 60 and over, and the increase that we can expect. You point out in your estimate that Mississippians age 60 and over will increase from 16 to 18 percent of the State's total population in the next 20 years.

What is the significance of that, in your judgment, in terms of the demand for health care services by the elderly population? Does that necessarily mean that we are going to see a corresponding increase in demand for health care services in this population group?

Mrs. Marshall. I believe we will. One reason is that with the changes in the medical and science technology, we have people living a lot longer. Now that people will be living a lot longer, and this population, as I said, will be the old-old, probably the one that needs the most social and medical care, then we are going to have people that are a lot frailer and a lot sicker, and probably have more problems that would be unique to that age than we have now.

And I think what we need to do is to not just concentrate on having the number of services we currently have now expanded, but look at additional services of another type that would address the needs of the older and the frailer of our population.

Senator Cochran. There was some specific suggestions that you made as you concluded the testimony, and I especially appreciate having the benefit of those for our hearing record.

One that you mentioned is a suggestion that the committee consider legislation to allow in-home services to become, without waiver, allowable along with others that are funded by Medicaid. What specifically, in your experience, is not eligible for funding or reimbursement right now that ought to be under that legislation?

Mrs. Marshall. I'm going to have to ask Eddie to help me on this one.

Senator Cochran. OK. Mr. Anderson.

Mr. Anderson. It is not so much what is or is not allowed for funding. It is just that having to go through the waiver process to do a demonstration program, that really ties our hands.

Right now in Mississippi, as you will see in the report, we have ten planning service areas. This is only being provided in four of those areas now. We have been working with our Medicaid offices for about a year and a half to expand it because it has proven to be successful. But given that it is only allowed now under the waiver, we cannot expand.

What we are saying there is that those kinds of services, in-home services, be allowed in the total array of what Medicaid provides, and not have to go through this special process in order to be implemented.

Senator Cochran. One other suggestion that caught my attention that you made in your concluding remarks was that the Health Care Finance Administration should recognize the Administration on Aging's network as the focal and entry point for older persons for in-home health care services, and that this network be sanctioned for case management of these clients.

Is that not now possible under our present Federal statutes? Tell me why that needs to be changed.

Mr. ANDERSON. What has happened is, as the population has grown and the kinds of things that are being provided via care plans by case managers, you have a lot of different systems operating out there. And what we are saying there in the recommendations is that the Administration on Aging, the State unit on aging, the area agencies on aging, they have a proven track record with providing services.

So, what we are saying is, with collaborative efforts that HCFA and the Administration on Aging together would sanction the network as the case management focal point, entry point mechanism, in the State for older clients getting into the system of getting these services.

Mrs. MARSHALL. In another way, Senator Cochran, to add some additional comments to what Eddie said, the system that we have, the area agency on aging and State unit on aging network, looks at services for older people that will cover an array of needs. Not only medical needs—we are talking about going beyond just the medical needs of an individual—but his or her social needs.

It will be the senior centers, the nutrition program that, of course, assists with the medical needs. But having that array of services that are funded through our area agencies would cover just about every need that that older person has, be it medical or social or whatever.

Senator COCHRAN. Another comment that was included in your testimony was that the eligibility and level of care requirements of home health services under Medicare and Medicaid should be reviewed and altered to remove present barriers and access to care.

Have we covered that in your previous answers to the two questions? Are those the barriers that you specifically had in mind or are there others that we haven't mentioned that we should know about?

Mr. ANDERSON. One thing that I have found is that there is a 50-visit limit for Medicaid clients. In a lot of cases once that 50-visit limit has——

Senator COCHRAN. This is the 50 visits from a health care professional?

Mr. ANDERSON. Right, right. From a home health——

Senator COCHRAN. From a home health service provider.

Mr. ANDERSON. Once that has been reached and if the need is still there, then that client is no longer eligible. And as well, I think that we need to look at the kinds of things that HCFA would pay for. I think there are other kinds of health needs that these home health agencies can provide that are not covered under present requirements and in the law.

Senator COCHRAN. Well, you have really gotten us off to a good start with an overview from a State perspective. I think this is a good way to have started the hearing. You have done a good job this morning, and we really appreciate you taking time to be with us to be our lead-off witness.

Mrs. MARSHALL. Thank you for the opportunity, Senator Cochran.

Senator COCHRAN. Thank you, Mrs. Marshall and Mr. Anderson.

Our next panel of witnesses includes family caregivers. And we want to call to the witness table at this time Mrs. Martiel Gager and Mrs. Alberta Johnson. Mrs. Gager is from Chunky, MS, and Mrs. Johnson from Philadelphia, MS.

They are here to give us a perspective of family members who are involved in providing assistance and care for older members of our society in Mississippi. We have statements from our witnesses, but we want to just ask them to proceed to tell us in their own words what their thoughts are and what their experiences have been and what our committee ought to know in connection with some of the practical problems that face families in dealing with some of these challenges in our State.

We will start with Mrs. Gager.

STATEMENTS OF MARTIEL GAGER, CHUNKY, MS; AND ALBERTA JOHNSON, PHILADELPHIA, MS

Mrs. **Gager**. I have my comments here. I haven't really had time to do a lot of work with it. But I'll probably have to read it a little bit.

Senator **Cochran**. That is just fine.

Mrs. **Gager**. I take care of my Aunt Angie who is 94 years old 24 hours a day, 7 days a week. She has lived in the same country home in Chunky, MS, since the early 1900's. Aunt Angie is one of five sisters. Two lived to their mid-nineties, one is still living at 98. The other passed away at 85 years.

Aunt Angie is a patient of Dr. Everett Scott, a cardiologist at Rush Hospital here in Meridian. She sees Dr. Scott on regular scheduled appointments.

Only when her medication has been changed or she goes to the hospital is she able to get home health care. As soon as she stabilizes or levels off, then home health care is stopped. She has gotten this scheduled home health care in the past. It has made life more comfortable and healthier for my aunt.

The most helpful part has been from the nurse's aide who bathes, shampoos, and gives her other necessary care she needs on a scheduled basis. However, when home health care is discontinued, it makes it very difficult for one individual to give the necessary care for that elderly patient that an elderly patient requires.

With me having to cook, clean, wash, bathe, shampoo, and administer medicine, and be up many nights, it is impossible to give my aunt the proper care.

Nursing home patients get scheduled continuous care all the time. They are not sent home when their condition stabilizes or neither is their care stopped. So, why can't elderly people who stay at home get continuous home care instead of having to be put in expensive nursing homes that cost the government and State a lot of money. They should be given equal health care at home.

Since elderly people are like babies, they need continuous care. That is why home health care is necessary for them.

Senator **Cochran**. Thank you very much for your statement, Mrs. Gager.

Mrs. Johnson, we are glad you are here. And we call on you now for your statement.

Mrs. **Johnson**. Thank you, sir. In August 1987, my mother was admitted to home care after a hospital stay for congestive heart failure. At that time, she was on numerous medications which required monitoring for signs of adverse side effects.

I had a poor knowledge of the medications, their proper dosage and side effects. I had never taken care of a severely ill person and knew little of the symptoms to watch for. My mother was extremely weak and frequently short of breath. She had difficulty getting around, and therefore required maximum assistance for daily activities.

Due to visits from the home health nurse, I became more familiar with her care, and I am able to call when I am in doubt about her condition. My mother has had frequent complications. But with interventions from a home health nurse, we have avoided many costly hospital stays. I feel her quality of life has been improved, and her personal needs have been met with the help of the home health care.

Senator **Cochran**. Thank you very much. In your experiences in dealing with older family members, whom you are very generously providing your personal care for, what went into your decision to remain at home with them and to provide this care rather than to seek some way of getting them into a nursing home or some other kind of situation where you wouldn't have this responsibility?

Mrs. Gager.

Mrs. **Gager**. Of course, love is the first thing. And since she had lived in this home and had been such a wonderful person to all of her nieces and all of her folks, and that she did not want to leave home, you know, at all, she probably just would not have lived had she have gone into some other situation. And, so, I decided—I gave up my job. I was out of State. And came back to her to keep her, and to make her happy, and make us all happy about it.

Senator **Cochran**. If you could write some changes into the laws or regulations that permit reimbursement for services, what would you consider to be one of the highest and best uses of service dollars to assist you in providing care for your aunt?

Mrs. **Gager**. I think I'm following you. Like I mentioned here, continuous home health care. It is almost impossible for one person to have to have that. Plus, I wouldn't mind have a little break. I understand other states and other places have—I have forgotten exactly what you——

Senator **Cochran**. We call it respite care.

Mrs. **Gager**. Respite care. OK. I get none of that, you see. And, really, it has boiled down that I am the one that is left for the whole—holding the whole thing for her. That is why I'm with her 7 days a week, 24 hours a day. And I do need that break.

Senator **Cochran**. Mrs. Johnson, in your experience, who have you felt comfortable going to to try to get assistance in meeting the challenges that you have in your health care experience with your family loved one? Have you gone to area agency officials or who have you sought out to provide assistance to you?

Mrs. **Johnson**. Well, first, Senator, I went through the doctor, and I asked him about help and home—you know, to come into the home. And the nurse, when I'm—I don't know which way to go or what to do, what is the next turn, I usually call her. It is good to have—they leave their numbers. And this is good that I can even through the night—they say if you need me during the night, call.

And this has given me so much consolation to know that I could call the nurse at any time and they will respond. I have had to call them a couple of times. And they were so generous to come right out or either to give information. They are so kind, and they are so generous when it comes to their help. And I'm really proud about that.

Senator COCHRAN. Do you have the same kind of feelings sometimes that everything is just up to you and that you need a break, like Mrs. Gager says?

Mrs. JOHNSON. This has really happened. This has really happened even though I have sisters that do come in every so often. But they have to come in from out of town. But you really get to where you feel that you are just in a rut or you are tied down, and you'd like to get away.

And I feel sometimes that if you get too overburdened with this pressure, you seem to not be as kind as you should be. You have to really get a hold of yourself and not to, you know, say the wrong thing. Because they are—my mother is 94, and I wouldn't want to hurt her feelings any kind of way. But you do need help. You need someone to assist you, to relieve you.

Senator COCHRAN. Has anyone that you have talked with provided any kind of encouragement or suggestions about how you could get respite care or some substitute person to come in and take your place for a little bit of time each week? Have you just sort of run into a brick wall in trying to find an alternative?

Mrs. GAGER. Exactly.

Senator COCHRAN. I'm sure that if we could design our program service delivery so that there would be some assistance available for those who are providing care in their homes just to get an afternoon off a week would be a real blessing to you, wouldn't it?

Mrs. GAGER. Yes. See, my aunt has no children. She is not married. So, there is really——

Senator COCHRAN. No other family.

Mrs. GAGER. No, there is just no one.

Senator COCHRAN. I think you have given us a perspective and understanding, a glimpse into your life and how it is affected by the thing that you've decided to do, and that is to remain at home and care for an older family member. It really highlights, I think, the human side of this issue that confronts us today.

And as families get scattered out all over the country with communication and transportation systems being what they are, people just don't stay at home as they used to. So, the society has changed so much over the last few generations when everybody was still sort of together, and now they are not. They are just scattered everywhere.

It makes it a different kind of problem for us. So, you have, I think, given us the benefit of information and observations that I think we will find helpful as we try to make sure that these programs are designed in such a way that they provide needed benefits and wise uses of tax dollars to help support services for our elderly.

Are there any other suggestions that you might have about what we ought to consider or new programs or changes in the programs that we have?

Mrs. **Gager**. I just wondered, you do understand what I'm saying about continuous home care. Not just——

Senator **Cochran**. Not just 50 visits.

Mrs. **Gager**. [continuing]. Just like a visit for two or three months, you know. I mean continuous for the person who really needs that. Because it has almost gotten impossible for me to bathe, you know, and to do all of the other necessary things because, naturally, she is going down hill more.

And if I only just had that help, it would—it meant the world to me when I did have it. And I have been on top of her medicine to the place that I got her to where I know exactly what to do and what to give, you know, and all that.

And the nurses aide is—no reflection against the nurse because I have a daughter that is a nurse—but the nurses aides are the ones that really give you the help that you need, to come in and bathe them.

It does something for the elderly patient, too, to have company that comes in there once in awhile although she may not recognize who they are. They will talk, and they are very nice to her. It just does something to her. When they get through with her, they will sit down on the bed and say a few things to her. She will ask them to. Just coming there two or three times a week just means the world, you know, to her. And, of course, it means a whole lot to me.

Senator **Cochran**. That is a very impressive description of the situation. Mrs. Johnson.

Mrs. **Johnson**. Well, for me it hasn't gotten to that point because I do have an in-law that lives near me. And she is very kind to come in at any time that I need to go into town or something. And that is good. Also, I have a sister that is not too far away, and we take turns.

So far, I haven't experienced what she has. And that means a lot to have someone near, you know, that is a relative. And elderly people feel better to know that it is a relative, I think. They feel more comfortable. But when you need help, you just need help from whoever.

Most of the aides and nurses, like she says, are very kind. They seem to understand just how to go about to communicate with the elderly. And this means an awfully lot.

Senator **Cochran**. Thank you. Thank you both for being here. You have really added a great deal to our hearing, and I really appreciate you taking time to be with us today. Thank you so much. Mrs. Johnson, thank you.

Our next panel of witnesses includes home health care providers. We have with us this morning—and I will ask them to come join us at the witness table—Ms. Helen McIntyre, who is a registered nurse and director of Riley Home Health Services here in Meridian; Ms. Jane Kennedy, who is director of the Southern Mississippi Area Agency on Aging in Gulfport; Mr. Dave Beck, who is District Administrator of District IV of the Mississippi State Department of Health at Starkville; Mr. Mike Greenhill, who is a representative of the Mississippi Association of Health Underwriters from Jackson.

We welcome this panel of witnesses to the hearing today. And we know that the statements that we have from this panel will help us understand some of the programs that are available to assist in providing home health care.

So, we want to go ahead and start off the panel with Helen McIntyre, Director of Riley Home Health Services.

Welcome, Ms. McIntyre. You may proceed.

STATEMENTS OF HELEN MCINTYRE, R.N., DIRECTOR, RILEY HOME HEALTH SERVICES, INC., MERIDIAN, MS; JANE KENNEDY, DIRECTOR, SOUTHERN MISSISSIPPI AREA AGENCY ON AGING, GULFPORT, MS; DAVE BECK, DISTRICT ADMINISTRATOR, DISTRICT IV, MISSISSIPPI STATE DEPARTMENT OF HEALTH, STARKVILLE,MS; AND MIKE GREENHILL, REPRESENTATIVE, MISSISSIPPI ASSOCIATION OF HEALTH UNDERWRITERS, JACKSON, MS

Ms. McIntyre. Thank you, sir. I appreciate the opportunity to come here today to defend home health. And I'd like to read my statement, if I may.

Senator Cochran. Sure. We welcome you to do that.

Ms. McIntyre. The title of my reading or the title of my talk today is "Proposals to Resolutions of Problems of the Health for the Poor, Frail Elderly."

Not only the State of Mississippi but throughout the United States the poor, frail elderly are being neglected, abused, exploited, and each one here today has reasons to express his displeasure loud and clear about the way this system has failed them or neglected them.

I am overwhelmed with ambivalence of the nation's feelings regarding the proposed improvements of the Medicare beneficiary. And this is commonly know as the Catastrophic Coverage Act of 1988. I feel the coverage was too broad and inclusive as it was written. If, perhaps, the coverage could have been over a longer span of time, it could have been a success not only for the recipients but also for the providers.

Previously, the payment of their $10.20 was to be $4 a month, and then it increased to $10.20 a month. And this would have been an addition to the $28.80 a month that they were already paying, which would have amounted to almost $40 a month that would have come out of a small check.

Forty dollars might not pose a problem for most of us here today. But I assure you, for most of the elderly it does pose a problem. I really think that is possibly one of the reasons that the Catastrophic Coverage Act did fail. The average senior citizen can barely pay for the necessities of housing, utilities, groceries, medicine, doctor bills, and deductibles.

You might say the main purpose of my speaking today may be stated in the following three points: The infirmed elderly person at home with fragmented caretakers, the needs of the mentally handicapped elderly who need protection from being exploited by relatives and so-called caretakers, the abused and neglected frail elderly.

It is said 80 percent of long-term care services are provided informally in the community by various caretakers. Some of these do a beautiful job of caring. And surely they are to be commended for this. But there is a limit to what caregivers can give. The burdens become so heavy.

And as was mentioned earlier, prospective payments and DRG financing has sent sicker patients to extended care facilities, whereby this reduces the number of beds that are available for them. Let's face these issues.

Mississippi has more nursing home beds presently than they do acute care beds. In fact, there are 17,022 nursing home beds as compared to 12,343 acute care beds. How many more nursing home beds can we afford?

Does the frail, mentally, and physically disabled person always require placement in a nursing home type care? My contention is that they do not. There are many of them that possibly could stay in assisted housing situations or remain at their own home. Many of them could go into a situation where they needed 24-hour custodial care which was nonmedical.

I feel that there should be a very strong policy written and enforced to the maximum to protect the vulnerable, poor, frail elderly.

I'd like to give you just one example of a patient that we had recently in our very cold weather in December. On December 22nd, the temperature was very low and the wind chill factor was below zero. An RN from my service made her way to another county to see a person who was bedfast.

When she got there—she said, "When I checked this person she was already experiencing hypothermia." She said, "I cried because she was cold from the waist down. She had frozen urine in her catheter bag. She had frozen urine in the tube leading from the bladder to the bag." I also cried when I heard that.

She phoned a local physician, and he advised the nurse to have the family transport the patient to the nearest emergency room. The family refused to do that. I think this is neglect. I think this is an adult abuse.

I do not know of a State, and I have lived in several states, that there are not strong laws to product small children from neglect. Cannot we have this same protection for elderly, vulnerable, senior people?

The last point I wish to mention is not least by any means in comparing the cost of home health care to extended care. I would like to give you an example of one patient in particular.

This patient was bedfast and had a condition that required daily visits to render sterile wound care. There was also a home health aide sent out to assist the patient with his personal care.

This period of care happened for 61 days, which is 2 months. They had a total of 95 visits. This cost Medicare $2,599. If this person had been in an extended care facility, had a bed been available locally, it would have cost $4,461. That is almost a thousand dollars difference.

I have one other patient I'd like to give you an example of. This little lady is 28 years old. She is maintained at home on a ventilator. In addition to the ventilator, her condition requires an oxygen concentrator, a suction machine, numerous sterile supplies. And for a two-month period she was visited by the RN for nine times.

All the equipment, all the supplies, and the visits costs Medicare a total of $3,501. If she could have gotten into a nursing homes, had a nursing home bed been available and if the nursing home would have accepted her with the complexity of her needs, it would have cost at least $4,458 for a two-month period. Possibly more.

I would not want to leave you people here today with the feeling that all the poor, frail elderly are poorly maintained at home. Some of them are beautifully maintained at home because they have very caring caregivers and they receive services from home health and also other agencies.

However, we must bear in mind that a person must have a particular need for a skill in order to qualify for home health service. He must need an RN. He must need a physical therapist, or he must need a speech therapist, or he must need an occupational therapist in order to have a nurse aide—which one of our earlier speakers said that she needed that nurse aide.

Now, I promise you today when a nurse aide goes out to render care to these people, the people get very close to them. And they see the need of the nurse aide more than they see the need of the registered nurse because of the type of care that they render.

With modern technology as it is today, the average life expectancy has far surpassed our 70 years. However, survival does not assure one of having functional capacities, nor the insurance of being maintained.

From a recent GAO study, projections indicate that by the year 2020, the total number of elderly may reach 51.4 million. That is a large group of people. And the group that is growing the fastest are those 85 and older. And they are the very dependent elderly.

Locally, greater than two-thirds of the people in long-term care facilities depend on Medicaid to pay for their care. And that is well and good. I think it should continue to be that way.

Recently I made some visits to some nursing homes in our area, and I found many people there that I felt could have been maintained in another type of situation, probably a custodial care facility had they had funds that would have helped them pay for that care.

I have several recommendations and proposals today. Would you like for me to read those, sir?

Senator COCHRAN. Well, we have a lot of witnesses here. I don't know how long they are, but you can use your own good judgment about the time that you need to convey the thoughts that you have to the hearing.

Ms. MCINTYRE. The Federal Government should provide each State with incentives to enter into matching programs for the Medicare/Medicaid beneficiaries. In order to participate matching funds, it would absolutely necessary for each State to establish stronger guidelines to provide more thorough screening of all Medicaid/Medicare applicants before approving funding for nursing home care.

I'm not opposed to nursing home care. There is certainly a need for it. But I certainly feel that those people who desire to stay at home should be allowed to stay at home. At the same time the screening was being accomplished, the determination could be made at that time whether another type of care could maintain this applicant.

I recommend that reimbursement to nursing homes be in comparison to the complexities of the services that they provide. Then thereby the facilities would be rewarded for admitting more patients with complex needs.

I recommend that the spin down program be reinstituted for Medicare recipients. However, I realize this has to be done on the State level. Had the Catastrophic Coverage Act passed, much of the above would not be necessary.

I further propose a policy be written to assist the remainder of the dependent elderly who want to remain at home. I feel like this could be done through some matching funds. I strongly favor extending the Medicaid waiver of liability provision. I'm in favor of enacting legislation to broaden the Medicaid coverage for home care such as respite and allow some funds to be paid to home caretakers.

Many of the caretakers have had to take leave from paying jobs to stay at home and care for the loved ones. I recommend that legislation consider allowing Medicare coverage for IV drugs in-home. This has been proven to be a savings to the Medicare system.

I oppose Medicare cuts including the Graham Rudman and the imposition of further copayments or beneficiary cost sharing.

In my conclusion today, I hope that every citizen not only here but in the State of Mississippi and the great United States of America is ensured an opportunity to live out his or her natural life span with dignity and with the least restrictive settings as possible whether it is in his own home, whether it is in the home of a relative, or in some type of supervised environment.

I also encourage each one attending today to voice your opinions to our own State legislatures. Many times we have not because we ask not. There is a statement by Matthew Henry, and it says, "There are none so blind as those of us who do not see."

[The prepared statement of Ms. McIntyre follows:]

PREPARED STATEMENT OF HELEN J. McINTYRE, R.N.

Not only in this state, but throughout the United States, the "poor frail elderly" are being neglected, abused and exploited and each one here today has reasons to express his displeasure loud and clear about the way the "system" has neglected them.

The ambivalence of the nation's feelings regarding the proposed improvements for the Medicare beneficiary, commonly known as the "Medicare Catastrophic Coverage Act of 1988, Public Law 100-360" is overwhelming.

It is my "GUT" feeling the coverage was entirely too broad and inclusive as it was written. If, perhaps, the coverage could have been over a longer span of time it could have been a success, not only for the recipients but also the providers.

It is frightening to the elderly when they hear their monthly checks are to be reduced, initially at $4.00 per month and increasing to $10.20 per month. This would have been in addition to the basic part B premiums which in 1988 was $28.80. Thirty-five to forty dollars might not pose a cash problem for most of you here today, but the average senior citizen can barely pay for the bare necessities of housing, utilities, groceries, medicines, doctor bills, deductibles, etc.

The main purpose for my speaking today may be stated in the following three points:

1) The infirmed elderly person at home with fragmented caretakers.
2) The needs of the mentally handicapped elderly who need protection from being exploited by relatives and "so-called caretakers."
3) The abuse and neglected frail elderly.

Referring to Point #1 above, it is said 80 percent of long-term care services are provided informally in the community by various caretakers and some of these do a beautiful job of caring and surely they're to be commended; however, being the realistic person that I am, there are limits to the burdens care givers can render. Economist and former Congressional Budget Office Analyst, Alice Rivlin, predicts that no more than 30% of older adults can realistically pay for long-term care privately. Prospective Payment/ DRG financing has sent sicker patients to extended care facilities, thereby reducing the number of nursing home beds available for the chronic frail elderly. Let's face the issues at hand: Mississippi has more nursing home beds than they do acute care beds. In fact, we have a third more nursing home beds, 17,022 as compared to 12,343 acute care beds. How many more long-term beds can any state afford? Does the frail, mentally and physically disabled person always require placement in a "nursing home-type" care. My contention is there is a need for [redacted]r custodian type care for many who fill the nursing home beds. Some of these could well function in an assisted housing situation which is non-medical. I just learned a week or so ago that the State of Oregon is pioneering a "special housing" for frail dependent older adults. In order to receive assistance through Medicaid at the present, one must be placed in a "nursing-home type situation." Could this same type of assistance pay a large portion to "licensed" personal care homes or domiciliaries?

Referring to my 2nd point above and that is, I feel that there should be a very strong policy written and enforced to the maximum to protect our vulnerable poor frail elderly.

For example, during our recent very cold weather in Mississippi when the temperature dropped to the low teens and the wind chill factors were well below zero, a home health nurse made her way on December 22nd to see a patient who is bedfast and totally dependent upon significant others for her care. In the nurse's own words, "I cried when I checked this patient because her vital signs indicated she was already experiencing hypothermia. The drainage tube from her indwelling foley catheter had frozen urine in it and the drainage bag was half-full of frozen urine; she was as cold as ice from the waist down." I cried also upon learning this. This nurse phoned a local physician and he advised the nurse to have the family transport the patient to the emergency room immediately. They refused. Is this neglect? Not only is it neglect, but to me [redacted]dult abuse.

I do not know of a state that doesn't have strong laws to protect small children from neglect and abuse, and it is well and good that this is so. I wholeheartedly agree...but, on a different vein of thought, would the R.N. have had the same protection if she had sent an ambulance to remove this poor soul from her environment-------possibly not, however, if I had been the nurse in this situation, you'd better believe I would have done this and faced the consequences later.

The last point above I wish to mention is not least by any means. In comparing the cost of home health care to an extended care, please note the following patient examples:

Patient #1 was bedfast and had a condition that necessitated daily skilled nursing visits to render sterile wound care. The caretaker received assistance from a home health aide to assist the patient with his personal care for a period of 61 days. The visits which totaled 95 and the use of multiple supplies for his sterile dressings cost Medicare $2,599. In an extended care facility, this same care would have cost $4,461 and that is if a nursing home bed had been available.

Patient #2 is bedfast and is maintained at home by his wife and the assistance of the home health services. He received a total of 69 visits by both the RN and nurse aide. He also received 24 hour tube-feedings for his nutritional needs along with multiple surgical dressings. This care cos Medicare $3,286 as compared to $4,458 it would have cost in a nursing home an if a bed had been available.

Patient #3 is a 28 year old woman who is maintained at home on a ventilator. In addition to the ventilator, her condition requires an oxygen concentrator, a suction machine and numerous sterile supplies. During a 2 month period she was visited 9 times. All the equipment, supplies and visits cost Medicare a total of $3,501 compared to $4,458 it would have cost in the nursing home, and again that is, if a bed had been available and her family could have found a nursing home that would take on the responsibility of such complexity.

As my closing thoughts today, I would not want to leave you with the feeling that all the frail elderly are poorly maintained at home. Many of our patients are maintained beautifully at home by significant others and with the assistance they receive from home health and other community agencies; however, bear in mind that a person must have a condition that requires a professional skill in order to qualify for home health services. We get many calls at Riley Hospital Home Health Services asking us to provide personal care to bedfast patients, but unless there is a need for a registered nurse, a physical therapist, a speech pathologist or an occupational therapist, the patient cannot be admitted to the services.

With modern technology as it is today, the average life expectancy has far surpassed seventy years; however, survival does not assure one of having functional capacity, nor the insurance of maintenance.

A few years ago, it was unusual for a person to live to be 100 years old, but, most every day or so, I read that a local person has reached his 100th birthday.

From a recent General Accounting Office study, "projections indicate that by the year 2020, the total number of elderly may reach about 51.4 million and of that number 14.3 million will be dependent upon others for help in caring for themselves over an extended period of time, plus the fact the number of dependent elderly in the community is expected to increase to 10.1 million." The number of those 85 years and over has been increasing at a greater rate than those 65 to 74 years of age. Over 50% of those 85 years old are in need of care compared with about 13% of those 65 to 69 years of age. As one can see, the most rapidly growing segment of the disabled elderly, the group 85 years and older, is the "very dependent".

The future frail dependent elderly may have to rely more on formal (nursing home) long-term care services as the availability of informal care givers decline due to increased societal trends such as smaller families, family members living far apart and women working outside the home.

Locally, greater than two/thirds of the people in long-term care facilities depend on Medicaid to pay for their care and I can understand why a nursing home would want to admit a patient who required less care. Naturally, it requires less help to care for an individual needing assistance with only a few ADL'S as compared to those who require special, labor intensive nursing care, such as tube-feedings, etc. These type patients are expensive to care for and are termed "heavy-care" patients. On the other hand, "light-care" patients are those with less complex or costly care needs. Recently, I made visits to some nursing homes in our area and I found many patients there who, it appeared, could have been maintained at home or in another type of custodial care facility if the funds had been available to assist them with the cost.

My recommendations and proposals are as follows:

1) The federal government should provide each state with incentives to enter into matching programs for the Medicare/Medicaid beneficiaries, and in order to participate in matching funds, it would be absolutely necessary for each state to establish stronger guidelines to provide more thorough screening of all Medicaid/Medicare applicants before approving funding for nursing home care. At the same time the screening was being accomplished, a determination could be made if other type of care could maintain this applicant. Also, I recommend that

reimbursement to nursing homes be in comparison to the complexities of the services provided. Thereby, the facilities would be rewarded for admitting more patients with complex needs.

2) I recommend that the "spend-down program" be reinstituted for Medicare recipients; however, I realize this has to be done on the state level. Had the Catastrophic Coverage Act passed, much of the above would not be necessary.

3) I further propose a policy to be written to assist the remainder of the dependent elderly who cannot privately pay for long-term care. Again, I feel this could be done through matching funds.

4) I strongly favor extending the Medicare Waiver of Liability provision.

5) I am in favor of enacting legislation to broaden the Medicaid coverage for home care such as respite, and allow some funds to be paid to home caretakers. Many of the caretakers have had to take leave from paying jobs to stay at home to take care of their loved ones.

6) I recommend that legislation consider allowing Medicare coverage for I.V. drugs in the home. This has been proven to be a savings to the Medicare system.

7) I oppose Medicare cuts (including Gramm-Rudman) and the imposition of further copayments or beneficiary cost sharing.

Senator **Cochran**. Thank you, Ms. McIntyre for your testimony.

We will now turn to Ms. Jane Kennedy, who is Director of the Southern Mississippi Area Agency on Aging.

Ms. **Kennedy**. Thank you, Mr. Chairman. Our Area Agency of Southern Mississippi encompasses the 15 southernmost counties of the great State of Mississippi where about 87,000 older Mississippians reside. Please accept our appreciation for being with you today.

You have given Area Agencies on Aging a congressional charge of leadership under the Older Americans Act. In return, we are committed to giving valid attention to all the areas of policy development which affects what we, as a society, do for older Americans.

We commend you for the diversity of representation in the hearing process here today. The involvement of multiareas, multigroups, and multiinterests can only serve to contribute to the education and enlightenment of all of us. And even as participation here today will hopefully move us forward more effectively, it may also serve as a life enhancing and empowering experience for the elderly themselves.

We are all aware that area agencies are responsible for a wide range of activities as the major catalysts for bringing about service development at the local level. We should make note that our responsibilities do not differ greatly from the Administration on Aging or the Mississippi Council on Aging except in sphere of authority and responsibility.

In Mississippi, not unlike all of the other states, the imperative of home and community based long-term care advancement derives from several realities including the rapid growth of a 75-plus population, generally higher service and living costs, particularly higher health care cost, the imperative of designing programs and appropriate levels of care with maximum cost benefit, the clear need to support family and other caregivers, and the necessity for interagency coordination and cooperation to achieve maximum response to need.

It is also recognized that older persons are a strong and durable population. Even when faced with health and financial problems, many State very positive outlooks on life. It is crucial that the personal preferences and priorities of older persons be given the very strongest consideration.

In our State, current service availability is woefully inadequate to their expressed levels of need. Virtually every supportive service reflects long waiting lists of potentially eligible individuals. It is especially noteworthy that most, if not all, of the services prioritized by older persons themselves speak to sustaining the individual in the most preferred environment—the home and community. This contention is also validated by the Area Agency Advisory Council.

A major concern for many of Mississippi's older adults is dealing with declining economic stability. Overall low levels of education have reduced the ability for many of the elderly to remain solvent through their retirement years. While some programs assist, most do not provide adequately for such major crisis as hospital care and costly prescription drugs and medication.

In the 15 southernmost counties, some 34 percent of persons 60 and older subsist at the establish poverty line. This rate is even higher in other parts of our State.

In developing service priorities and targeting goals, the area agency attempts to base these goals on appropriate policies and procedures. We use the findings of two important sources of interpretive data that were mentioned here by Mrs. Marshall earlier: The Mississippi Council on Aging Needs Assessment which possibly stands as the most current statewide assessment in the nation; and the Report of the Governor's Interagency Coordinating Committee on Long Term Care for Older Mississippians.

This massive, statewide needs assessment validates that the overwhelming majority of older persons wish to retain a sufficient level of independence and self care in order to remain in their own homes, neighborhoods, and communities. As to preferred living arrangements, 79 percent of the respondents State the family dwelling as the arrangement of choice.

Therefore, planning is and should be focused in this direction. The intended result, of course, is that larger numbers of older persons remain independent as long as possible, and more importantly, are much more satisfied with their lives.

The Medicaid Waiver for Home and Community Based Care three-year pilot project has recently seen completion in our area. We anticipate an extension of the waiver and hope to realize its potential as the basis for Medicaid and aging resources statewide and their consolidation.

While much data has been extrapolated from the waiver experience, one specific comment always resounds in my own mind. It was made by a waiver participant's family caregiver. She said, "Just knowing there is respite waiting if my help fails, brings me sweet sleep if I give out just for today." An examination of the record of service for that family indicated that of the 30 days of respite allowed, not one day had yet been consumed.

Only if Mississippi is positioned to accommodate the shifting roles in long-term care financial support can we benefit from the public/private partnerships we see evolving in other states which now enjoy better developed or more well developed delivery systems. Our State supports Older Americans Act resources by only the minimum match required. We must continue to advocate for increased financial support and the strongest possible committment of State leadership to this end.

Collectively, the amount of funds provided by local governmental units in our planning and service area alone exceed the total contribution of our State. The one county considered the most economically deprived consistently supports aging services through contributions much greater than the county's equitable share of Federal/State funds based on population and poverty.

The Area Agency undertakes activities on a regular basis designed to facilitate the coordination of these resources. Those of public and private organizations including units of local government which have responsibilities that may promote benefits and opportunities for older persons.

We must not overlook the support of older volunteers who provide thousands of hours of service in the network each year. They are particularly effective with their cohorts. It becomes increasingly important to expand existing volunteer programs to generate citizen and volunteer involvement both as a cost-effective alternative and efficient mode of service delivery. These groups play an important part in the education of local leadership in carrying out their responsibilities in support of the national endeavor to build responsive community care systems.

All of these are difficult and complex issues. And interpreting them in order to rationalize and recommend a proper course of action always leads us back to that one overriding desire of the vast majority of older persons who wish to remain independent as long as possible and seek those services which respond to health and social needs, particularly the need to be a valued community member, and search for those programs which enhance economic well-being. Thank you Senator Cochran.

[The prepared statement of Ms. Kennedy follows:]

Statement of the Area Agency on Aging of Southern Mississippi
JANE KENNEDY, DIRECTOR

Introduction

Mr. Chairman, distinguished members of the Subcommittee on Aging:

My name is Jane Kennedy and I am Director of the Area Agency on Aging of Southern Mississippi which encompasses the fifteen southernmost counties of the state where some 87,000 older Mississippians reside. Please accept our appreciation for the privilege and opportunity of presenting this statement.

You have given Area Agencies on Aging a congressional charge of leadership under the Older Americans Act. In return, we are committed to giving valid attention to all areas of policy development which affects what we, as a society, do on behalf of older Americans.

We commend you for the diversity of representation in the public hearing process. The involvement of multi-areas, multi-groups, and multi-interests serves to contribute to our enlightenment and education. And even as participation here today will hopefully move us forward more effectively, so may it serve as a life-enhancing and empowering experience for the elderly themselves.

The degree of heightened community awareness - of institutional bias, prejudices, abuse, exploitation, neglect, victimization, and the remedies thereof; of achievement, contributions, wealth of resources, wisdom, life experience and the value thereof - - - will greatly and finally determine our success or failure in most profoundly affecting the marketplace of social change for older people.

Overview

Area Agencies on Aging are responsible for a wide range of activities which involve: (1) development of an area plan for a comprehensive and coordinated system of services to meet the needs of older persons, (2) funding service providers to fill gaps in priority service areas, and (3) serving as the advocate and focal point for older persons within the planning and service area. As the major catalysts for bringing about services development at the community level, it should be recognized that Area Agencies on Aging function in full partnership with the Administration on Aging and the Mississippi Council on Aging, therefore, their functions do not differ greatly from those of the State Unit on Aging except in scale and sphere of authority.

Area Agencies are instrumental in representing the views, problems, and concerns of older persons at the local levels. This advocacy role is challenging because of the wide range of specialized issues to be dealt with. For purposes of this discussion, we will offer information in the broad area of community based long term care with focus on in-home health care and supportive services.

The Issue

Care of the elderly, particularly those most vulnerable and at risk is a crucial and complex issue of concern to all levels of government. Without a doubt, the challenge of addressing the long term care needs of our rapidly aging population is the major national priority area of concern presently occupying policy makers, administrators, and practitioners.

In Mississippi, not unlike other states, the imperative of home and community based long term care advancement derives from several realities including the rapid growth of the 75+ population, generally higher service and living costs, particularly higher health care costs, the imperative of designing programs at appropriate levels of care with the maximum cost benefit, the clear need to support family and other caregivers, and the necessity for interagency coordination and cooperation to achieve maximum response to need. It is also recognized that older people are a strong and durable population. Even when faced with health and financial problems, many state very positive outlooks on life. It is crucial that the personal preferences and priorities of older persons be given the very strongest consideration. In our state, current service availability is woefully inadequate to their expressed levels of need. Virtually every supportive service reflects long waiting lists of potentially eligible individuals. It is especially noteworthy that most, if not all of the services prioritized by older persons speak to sustaining the individual in the most preferred environment -- the home and community. This contention is also validated by the Area Agency Advisory Council.

Further, it is estimated that 75 to 80% of all care given to the elderly in the home is offered by natural support systems -- family, neighbors, and friends. It is vital that service systems not usurp this support, but rather enhance and sustain community caregiving. There is, however, highly indicated evidence that family members perform caregiving tasks much better if they have assistance from social services and health care professionals.

While continuing and sustaining initiatives directed towards the establishment of home and community care systems for all older people, efforts must also be directed to the complexities of the changing needs of various subsegments among the total 60+ population including the special populations of low income, minorities, rural and frail elderly, and those of advanced age.

A major concern for many of Mississippi's older adults is dealing with declining economic stability. Overall low levels of education have reduced the ability for many of the elderly to remain solvent through their retirement years. While various programs assist, most do not provide adequately for such major crisis as hospital care and costly prescription drugs and medications. In the fifteen southernmost countries, some 34% of persons 60 and older subsist below the established poverty line. This rate is even higher in other parts of Mississippi.

Strategies for Strengthening Home and Community Care

Building upon the identified service needs and priorities of older persons, emphasis has been given to strengthening the service delivery system to do the job. Strategies for achieving improvements take into account existing service levels, historical evolution of the service systems and geographical and political boundaries of the community. We rely on community input, surveys and assessments, public hearings, special studies and task forces, and population statistics. Cost benefit analyses are used where feasible and appropriate. In order to properly direct and implement alternative strategies, the Area Agency has written policies and procedures for reaching its goals, a free and open service provider selection process, procurement standards and procedures to ensure coordination between the participating organizations. Data based management systems are used to preserve and extend local accountability.

In developing service priorities and targeting goals based on appropriate policies and practices responsive to current and potential needs, the findings of two important sources of interpretive data are presently considered: the Mississippi Council on Aging Needs Assessment which possibly stands as the most current statewide assessment in the nation; and the Report of the Governor's Interagency Coordinating Committee on Long Term Care for Older Mississippians.

This massive, statewide needs assessment validates that the overwhelming majority of older people wish to retain a sufficient level of independence and self care management so as to remain in their own homes, neighborhoods, and communities. As to preferred living arrangements, 79 percent of the respondents state the family dwelling as the arrangement of choice. Therefore, planning is and should be focused in this direction. The intended result is that larger numbers of older persons remain independent as long as possible, and more importantly, are much more satisfied with their lives.

Older adults who do not experience feelings of loneliness and isolation are those who maintain rich and varied social exchanges. There are strong relationships between overall life satisfaction and the extent of sociality. A major finding of the study indicated that those reporting significant levels of life dissatisfaction, also reported disabilities in social relationships, lack of awareness of services and entitlement, serious emotional problems, high stress and high levels of loneliness. Community programming which focuses on social interaction of a group nature could greatly enhance levels of life satisfaction. Those programs which ensure ongoing social opportunities need to be continued and enhanced to include health based models such as day care.

Therefore, it is strongly recommended that programs to assist the elderly be based on the proven social psychological principles of (1) involving the elderly in planning and carrying out the programs that affect them; (2) giving older adults a share of the responsibilities so they can gain a feeling of self-worth; (3) providing opportunities that are challenging to them and that recognize their contributions; (4) encouraging creativity, that is, drawing upon their life experiences to find new and better ways to help themselves and others.

The Medicaid Waiver for Home and Community Based Care three year pilot project has just recently seen completion. We anticipate an extension of the waiver and hope to realize its potential as the basis for consolidated Medicaid/Aging long term care resources statewide. While much data has been extrapolated from the waiver projects one specific comment offered by a waiver participant's family member resounds in my mind. She said "Just knowing there's respite waiting if my health gives out brings me sweet sleep when I give out just for today". An examination of the record indicated that of the thirty days of respite allowed not a single day had been consumed.

Only if Mississippi is positioned to accommodate the shifting roles in long term care financial support can we benefit from the public/private partnerships we see evolving in other states which enjoy well developed delivery systems. Our state supports Older Americans Act resources by only the minimal match requirement. We must continue to advocate for increased financial support and the strongest possible commitment of state leadership to this end.

Collectively the amount of funds provided by local governmental units in our planning and service area alone exceed the total contribution of the state. The one county considered the most economically deprived consistently supports aging services through contributions much greater than that county's equitable share of federal/state funds. The Area Agency undertakes activities on a regular basis designed to facilitate the coordination of resources of all public and private organizations including units of local government which have responsibilities that may promote benefits and opportunities for older persons.

We must not overlook the support of older volunteers who provide thousands of hours of service in the aging network each year. They are particularly effective with their cohorts. It becomes increasingly important to expand existing volunteer programs to generate citizen and community involvement both as a cost effective care alternative and as an efficient mode of service delivery. These groups play an important role in the education of local leadership in carrying out their responsibilities in support of the national endeavor to build responsive community care systems.

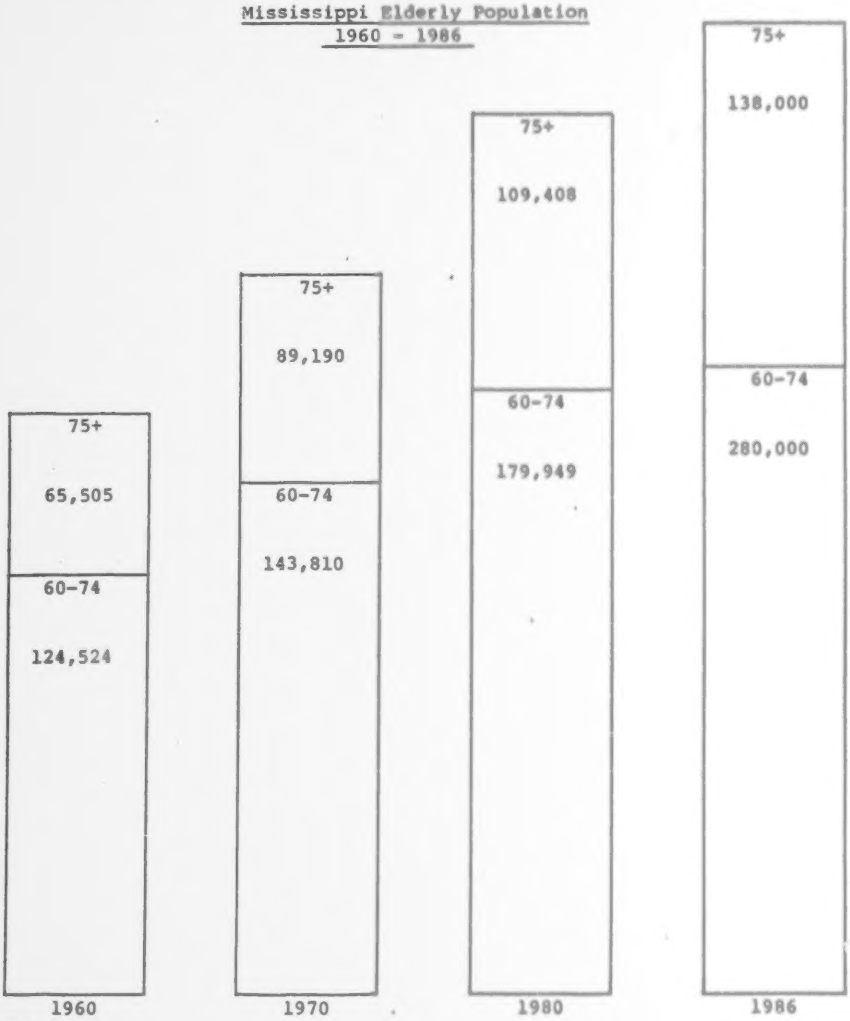
Interpreting these myriad and complex issues in order to rationalize and recommend a proper course of action leads us always to the one overriding desire of the vast majority of older person who

> - - - wish to remain independent as long as possible and seek those services which respond to health and social needs, particularly the need to be a valued community member, and search for those programs which enhance economic well-being.

Population Growth and Trends

The number and proportion of persons 60 years old and older in the United States is growing rapidly, including a phenomenal increase in the very old; those individuals 75 years old and over -- a subsegment of the population especially at risk for long term care. Mississippi is no exception to these population trends with 16% of the state's population represented by this group or 418,000 in 1986 which is one in every six Mississippians. There are approximately 138,000 persons 75 or older.

Mississippi Elderly Population
1960 - 1986



(1676K)

Mississippi Demographics (U. S. Census Bureau Data)

Population 60 years old and older (1980 Census)	392,603
As percent of total population	15%
Number living at or below poverty level	160,967
Percent living at or below poverty level	41%
Population 75 years old and older (1986 Census Estimates)	138,000
As percent of total older population	35%

For Mississippi this figure represents a 49% increase in the number of persons 75 years old and older between 1960 and 1986. This age group is the group most likely to suffer from chronic health conditions which leave them unable to perform activities of daily living without assistance; these elderly are the one segment at highest risk of institutionalization sometimes prematurely or inappropriately.

Social gerontologists note that, nationally, while some 33 million persons currently report some limitation of activity due to chronic conditions, these numbers will soar to 43 million by the turn of the century. The largest increase will be among the group 75 years and over. In Mississippi, future projections indicate a 22 percent increase in persons having limitations in daily living activities and an 11 percent increase in physician visits. Clearly, it is this age group which will make major demands on home and community based long term care systems and facilities. As the Mississippi State Health Plan - 1986 states:

> "...no matter what steps are taken to improve the plight of our states elderly population eventually more resources from state, local and national governments will be required to meet the need for care..."

The alternative, as the plan further relates, is to do nothing. The avoidance of confronting these issues in an orderly and wisely planned manner can only lead us to the brink of social and economic disaster. Implications stemming from moral apathy are indeed grave. This planning document attempts to blue print a sense of direction as the aging network responds to the urgent challenge of long term care.

Senator **Cochran**. Thank you, Ms. Kennedy, for your very fine statement.

We will now hear from Mr. Beck, who is—I've got your title right here in front of me—District Health Administrator for District IV, the State Department of Health. Welcome.

Mr. **Beck**. Thank you, Mr. Chairman. The Mississippi State Department of Health has been a provider of home health services since the inception of the home health program in the 1960's. At present the Mississippi State Department of Health, the state's largest home health agency, is providing a complete range of home health services in all 82 counties.

It is estimated that during the current fiscal year, approximately 9,000 unduplicated patients will be served by us and that approximately 270,000 home health visits will be made. Through the provision of services to thousands of clients throughout the State over the last two decades, we feel that we have been able to gain a great deal of insight into the need for home health services, the impact that the current services are having, and the areas in which gaps in services currently exist.

To ascertain the potential need of home health services, one need only look at the elderly population and their economic status in Mississippi. There are approximately 45,000 persons age 60 or over of which over 40 percent have incomes below the poverty level. It has been the department's past experience that of those patients referred to our home health program, approximately 88 percent of them were 65 years of age or older, and 20 percent of those patients had no pay source.

If this approximation was figured statewide for all home health patients, regardless of the agencies providing the service, approximately 6400 individuals needing home health care would meet the definition of low income and have no access to home health services because they do not have a pay source.

Further accelerating the need for home health care has been the institution of the DRGs. As a result, the department is seeing a much larger percentage of home health patients who need a higher level of skill care once discharged from the hospitals. Clients are having shorter hospital says resulting in a greater proportion of the recuperation being done at home.

In addition, the lack of subsidized home health care has resulted in services being terminated because of patient's loss of eligibility for Medicare/Medicaid benefits creating a major gap in patient care. Consequently, the absence of a home health program for this population has resulted in prolonged in-hospital stays and needless institutionalization.

In a effort to address those people who are in need of home health type services but have no pay source, and to address other needed and related health services, the Mississippi State Department of Health has applied for and received a grant for the provision of home health care services. The goal of this project is to demonstrate and document that if skilled medical services and/or related health services are provided in the home, institutionalization or prolonged hospitalization can be avoided.

This project is currently operational in a four-county area of northeast Mississippi and will be expanded into six other counties by March of this year. Patients for this program are being selected from referrals on the basis of having an income of less than 185 percent of poverty, a high probability of frequent and prolonged hospital or institutional stays, a stated desire and ability to receive home based services, and an inability to purchase or otherwise obtain the needed health services through other sources. This program is open to all age groups so that a representative cross section of the population will be served.

Each prospective client is screened and assessed by a multidisciplinary team consisting of nurse, social worker, and physician. In addition to an assessment of needed medical services, a psychosocial assessment is performed to identify those social, emotional, and economic factors which interfere with the patient's ability to benefit from health services which are being provided and to attempt to eliminate or ameliorate these identifiable problems through intensive case management, direct revision of services, and obtaining related service through networking with exist human service agencies such as the Local Area Agency on Aging, the Department of Public Welfare, the Department of Mental Health, churches, and civic organizations.

It is our firm belief that through effective case management and the provision of necessary medical care, that at-risk patients high probability of hospitalization or institutionalization can be significantly reduced enough to produce a very positive cost benefit ratio.

Indeed, the potential significance of this model program can be illustrated by looking at the nursing home admissions during a recent year in Mississippi. During that year there were 7,980 admissions of which 4356 or 54.6 percent were low income. It is conservatively estimated if that group had had access to home health services, at least 25 percent, over a thousand persons, could have avoided costly and needless institutionalization.

Two patients currently being served through the demonstration project clearly exemplify what these statistics merely suggest.

The first patient is a 59-year-old female who has diabetes and hypertension and is a double amputee. This patient lived with her only child until the child's death nearly two years ago. After the child's death, the patient having no support system entered a nursing home where she remained for approximately 17 months.

Her desire to live her life outside of an institution was so great that she checked herself out of the nursing home and moved in with cousins who made a small addition to their home so she could have a place to live. The patient does not have Medicare or Medicaid at this time. In order to prevent her future reinstitutionalization, the project is providing a home health aide three times per week to assist with daily living skills, periodic RN visits to check blood sugars, and a social worker has requested an evaluation of her house so that modifications can be made to facilitate the patient's utilization of the bathroom's facilities with a minimum cost to the support family.

With her extremely strong will not to be institutionalized and with the aforementioned services, the prognosis is excellent that she will not have to be institutionalized in the foreseeable future.

The second patient is an 82-year-old female who suffers from an organic brain syndrome, has tuberculosis and is completely bedridden. She does not currently have Medicaid due to moving from her home that she owned to a rental house. Her primary caregiver is her elderly husband who spends all but two hours every day with her. The project is providing a home health aide three times per week to provide personal care, and is supplying the much needed diapers and blue pads.

The social worker is assisting the family in having Medicaid review the case. The local health department is treating the patient for tuberculosis. Without the intervention of the project, it is extremely doubtful that her elderly husband could continue his tireless efforts in keeping his wife at home. It is also quite likely that without this intervention, the health of the husband might deteriorate to the point that both of them would have to be institutionalized.

These cases are representative not only of their will to remain at home, but they also illustrate the financial and emotional burden that weighs heavily on their families. These families are making tremendous personal sacrifices in order to allow a loved one live out their life in a setting of their own choosing and with dignity that every citizen should expect.

These citizens deserve the respect and support of their government. It seems to me that the choice is either to support these citizens in in their effort, or to accept the alternative of financially and emotionally devastated families, and the involuntary and unnecessary institutionalization of many of our citizens. Thank you.

Senator COCHRAN. Thank you, Mr. Beck, for your very helpful statement.

We will now hear from Mike Greenhill who is representing the Mississippi Association of Health Underwriters.

Mr. GREENHILL. Thank you, Senator. I appreciate the opportunity to testify today. Many times the private insurance industry is left out. And I think this problem is going to take the public and private sector to solve it as enormous as it is in this country.

Our industry perceives home health care and long-term convalescent care almost synonymous. In many cases, home health care and long-term care or home health precedes institutionalized care.

The following statements are made on behalf of the Mississippi Association of Life Underwriters and the Mississippi Association of Health Underwriters. They are submitted as feasible ideas that would improve this industry for senior consumers, convalescent care providers, insurance regulators, legislators, and the insurance companies involved in marketing convalescent care policies.

Medicare presently provides reimbursement for home health care as long as there is a medical skilled service performed on the home health care visits. These services are administered by RN's, LPN's, and home health aides. Benefits must be recertified every 60 days. However, Medicare provides no coverage for custodial care at home.

Custodial care at home is best defined as assistance in getting in and out of bed, using the bathroom, bathing, dressing, preparation of meals, and other aspects of normal everyday activities. Some seniors are unable to perform these simple functions without help due to physical frailty or organic brain disorders such as senility or

Alzheimer's disease. Since medical services are not performed, they fall through this gap in the Medicare coverage.

We recommend that the Federal Government create incentives for private industry to develop coverage for custodial home health care and long-term nursing care programs. By giving insurance companies the same tax favored treatment for premium reserves for these type policies that are presently allowed for life insurance, more insurance companies will enter this market.

A minimum floor of nursing home coverage should be provided by Medicare for all senior Americans. Middle and lower income groups have few options available when nursing home care is necessary. Their assets are used up quickly and they are forced to accept less than adequate care.

Medicare provides a very limited coverage for skilled nursing facility care on a posthospital basis. The maximum benefit period is only 100 days. This is a reduction from 150 days of skilled nursing facility care available under the 1989 Medicare program. It is included in the Catastrophic Care Act. Also, I mentioned that Catastrophic Care did not require hospitalization for nursing home admission. Medicare coverage should include all levels of nursing home care. Custodial and intermediate level, specifically as these constitute almost 98 percent of all nursing home confinements.

We advocate relaxing the criteria for Medicare qualified or approved facilities. At the present time there are only 20 Medicare approved skill nursing facilities in Mississippi. Make it easier for nursing homes to qualify for Medicare approved status. This will provide more options, more freedom, and more independence for our seniors.

We advocate a tax deduction for private supplemental convalescent care and home health care insurance premiums. This would encourage senior Americans to protect themselves against financial loss created by long-term convalescent care.

We feel that anyone willing to step up to the plate, pay a premium to continue to be self-reliant without—and refuse government assistance, they ought to get a tax break for it.

We support a 1-year preliminary term reserve method for long-term care insurance policies and home health care insurance policies. This method, as has been proposed by Larry Gorski, an actuary with the Illinois Insurance Department, would substantially strengthen the industry as a whole and individual insurance companies.

Our senior Americans need to know they are dealing with companies that will be solvent and able to pay claims when the loss is incurred. The current wide practice method of reserving at the end of the third year does not provide this protection.

Agent training is critical. There are many untrained or poorly trained agents on the street currently selling long-term and home health care policies. We support concurrent educational programs for all agents involved in any type convalescent care insurance sales with recertification every three years. This should be a joint effort between insurance companies and State insurance departments.

Tax relief is also important. Expenses for long-term care should be eligible for the same personal income tax credits as medical costs. Tax credits for out-of-pocket expenses and premium payments for long-term care and home health care insurance will provide seniors incentives to prepare for their future care needs.

Tax credits should be offered to younger adults for money they spend to purchase long-term care services and insurance for older parents or relatives. The dependent support test, which requires 50 percent of an elderly relative's total support before they can claim the relative as a dependent, should be eliminated. This would provide relief to families facing high nursing home and home health care expenses.

Federal tax laws should be changed to allow long-term care insurance to be offered in employee benefit packages, similar to tax-qualified retirement accounts. This would allow younger Americans to prepare for their senior years now. From an industry standpoint, the insurance companies would be able to profitably provide this type coverage because the policies would be in force longer.

We could sell long-term care as an asset protection vehicle rather than an imminent need product. Workers and retirees should be allowed to use funds from pension plans, 401K plans, IRA's, and other retirement plans to make tax-free purchases of long-term care insurance.

Universal life insurance cash values should be allowed to be withdrawn tax free to purchase long-term convalescent care policies or used to pay for long-term care expenses. We oppose the taxation of the internal build-up of cash values in life insurance. Quite frankly, the purpose of these assets are to allow policyholders to avoid dependence on governmental assistance in their senior years.

We oppose the leveling of commissions for sales of Medicare supplement and convalescent care type insurance policies. If our industry is not able to make a living selling these type coverages, the distribution of the products are going to decrease and the market penetration will substantially—will also reduce substantially. Again, I thank you for the opportunity to speak.

Senator COCHRAN. Thank you very much for bringing us that perspective and those suggestions for consideration. Mike Greenhill, thank you for being here.

In looking over the testimony and recalling the various suggestions and comments that were made, I think we have really gotten a wide range of input here from this panel, which I find very interesting and also very helpful.

I remember Mrs. McIntyre's comments about the Catastrophic Coverage Act which turned into a white elephant pretty quickly after it was passed because of the near revolution that was caused among the older citizens who found out they were going to get to pay for it by increasing the premiums and imposing the responsibility on that segment of our society.

And because of the pressure that built up on the Congress, that act was repealed. What was not changed, though, one thing that needs to be pointed out, is the requirement for people to spend down their assets. That did stay in the law. That changed in the law. So, that is an advantage, I think, that we did get. If there is a benefit from that entire experience, that is probably it. You don't have to spend down as much of your income before Medicaid will pay for long-term care for one spouse. That is an interesting change and important provision that came from the Medicare Catastrophic Coverage Act.

But my question, I guess, that I wanted to ask you is that because of that expression of opposition that we heard from senior citizens who were going to be taxed, in effect, for that program, what do you think the likelihood is for getting support among older citizens generally for any kind of added cost for custodial care programs or home health care services? If Congress passed any expansion of existing program benefits and then required, in return, older citizens to help pay for that through some kind of premium charge, would we be able to get that sustained, or is the opposition going to be so great that that won't be possible for the future? What is your reaction to that?

Ms. **McIntyre**. My opinion is that possibly they would have supported it if they had not thought it would have continued to increase each month. As I said, $40 may not pose a cash problem for many of you, but it does for many of them. Many of them have medication that amount to up to $200 a month. And with a check of $400 or less, what does that leave them?

Senator **Cochran**. One of the proposals was—I think when the Secretary of HHS, Dr. Bowen, first recommended the Catastrophic Coverage Program the expected premium charge was going to be about $5 a month. And what happened was Congress, you know, took a good idea and expanded it into a bad idea by adding so many more new benefits to it and then increasing the cost to pay for those new benefits that it got it out of proportion to the ability to pay for a lot of senior citizens. Is that what happened in your judgment, too?

Ms. **McIntyre**. Yes, sir. I think so, too.

Senator **Cochran**. So, a more modest premium charge might be acceptable. One thing, too, I think we forget is that that Catastrophic Care Act did not provide coverage for chronic illness. It was simply for short-term health care problems.

Would there be greater support, do you think, for added premium charges if we were talking about custodial care, long-term care, home home health care services, and not just short-term benefits?

Ms. **McIntyre**. Possibly so. Possibly so.

Senator **Cochran**. Ms. Kennedy, I noticed in your testimony you mentioned some of the experiences you have had under this waiver experiment and that you hope that can be continued. There are some private groups that provide services for the elderly and I specifically know of the United Methodist Senior Services which we heard from when we had our hearings in Tupelo.

How do they work with you, your agency, through the Older Americans Act or through the community based waiver program to provide services to senior citizens?

Ms. **Kennedy**. United Methodist Senior Service is, of course, a statewide private, nonprofit. They were one of the forerunners in the provision of home health having been one of the first home health care agencies in our State. They work with Area Agency in the southernmost part of the State as the designated provider of homemaker services under the provisions of the waiver as one of the allowable services.

They also contract with us for the provision of care management or case management, as more commonly known, with Title III-B under the Older Americans Act. I made mention in my testimony or statements here today that we are not yet experiencing those decided financial options, so to speak, of how to approach this whole dilemma and home and community based care financing and cost containment and, of course, the quality of life considerations, too.

I think one of the reasons I feel confident in saying that is because, for instance, United Methodist Senior Services as a private, nonprofit contributes a great deal of their own resources to the array of funding mechanisms that come together to make our home and community based care systems a reality in our area. These are private funds given generously by the sponsoring church of that particular organization.

And I think they also have been very innovative in looking to us to begin cost sharing, for instance. Cost sharing where older persons who need the service but cannot find it within the community, but do have the means to cost share based on their individual needs. We need to direct more attention to the potential of those kinds of innovative approaches to financing the array of care.

Senator COCHRAN. When Mr. Beck testified, he mentioned a pilot program. I guess the waiver program is a pilot program, in effect. You are recommending it be continued, as I understand it.

Do we need to legislate that or is that an administrative decision? I'm not exactly sure how we do that.

Ms. KENNEDY. The Medicare waiver is negotiated with HCFA, of course, in our State Medicaid office. In our State it is a partnership with the Mississippi Council on Aging as well. We are currently in the process of those negotiations being finalized.

The model project approached different strategies for the payment system or the brokering of services under the care system. And I think that negotiation is still going on.

Please allow me to say in relation to that, that it is indeed heartening to us as a part of the aging network to note that the Administration on Aging, the Social Security Administration, and HCFA have a decided written interagency agreement now which spells out for each of those agencies their specific role in collaborating together in addressing the cause of home and community based care. That is very reassuring to us.

Senator COCHRAN. One thing I remembered when we were taking up the Older Americans Act in our committee when it was reauthorized the last time, I offered an amendment to require that the Federal Council on Aging, the Advisory Committee for the Administration on Aging, be composed of at least one-half of those who were old enough to be served by the Older Americans Act so that we would have input from older people who could tell the administrator what they wanted and what they thought the benefits ought to be. And I think that has worked well.

One of the first additions to that Council, incidentally, who was from that population group was a person from Clarksdale, Mississippi. I recommended to President Reagan that he appoint Newton Dodson from Clarksdale. And he served and has served on that Federal council. So, our State has representation now on the council. And that is good when we see them meeting in Washington to have somebody from our State who can express our concerns and make sure that our needs and interests are considered when they are talking about these things like extending the waiver.

Is there any way that you can think of that I could personally be of assistance in a successful negotiation of this waiver renewal? Or are we out of——

Ms. KENNEDY. No, no, no. Indeed, we are not. And let me say, if I may again, Senator, how much we appreciate your past advocacy on behalf of older Mississippians and older persons in general. Your participation here today and on the panel, and your track record for supporting and examining closely the issues, and supporting those that seem fitting has been a great asset to us in our State in planning. And we appreciate that greatly and commend you for it here today.

I think one of the obstacles here—and, of course, there may be others who have a particular opinion—is the economic condition of our State causes us some fear about the floodgates opening, if you will, and demand for care under the Medicaid waiver, and how in the world will we continue to finance it and be able to respond to that great demand.

So, of course, those considerations are being looked at closely in the area of cost containment. I think that we might look at all the experiences nationwide very closely and recognize that while there might be initial heavy demand—as I mentioned about the lady who said it is good to know the respite is there, but I'm making it okay for today. We think that older persons will do just that, their very best to stay independent without I'm entitled to this and I must have it and it must be there, which are considerations.

Senator COCHRAN. Well, those are very incisive comments, very thoughtful; and we appreciate having your opinions about it because you work very hard.

I can remember a hearing when I first went on to a special committee on aging in the House of Representatives. We had the hearing in Jackson on the economic problems of the older citizens of our State. We had two or three members of Congress come to Mississippi and help conduct that hearing. And I remember your testimony on that occasion. That was—I'm not going to tell everybody how long ago that was, but it seems like it has been——

Ms. KENNEDY. I must admit, Senator, after 18 years in the network I have just had my 60th birthday. So, now I am one of those we are attempting to serve. Just as the Federal Council on Aging has their representation, so does our area.

Senator COCHRAN. That is a very interesting thing. Well, congratulations on reaching that milestone.

Mr. Beck, you really told us something I think we needed to know about the pilot project. Just as matter of comment, you described a project that was authorized in the Older Americans Act just this past go round where we saw Mississippi designated as one of the five states eligible for some funds for a Federal demonstration project. That was designed to create a model of comprehensive home health services that could help elderly avoid care in institutions if that would be their choice. And I appreciate your being here today to describe the pilot project and what you are doing.

My question is: Do you see a need for this kind of effort, experimental pilot project, to be continued? We may have to reauthorize that by legislation in order to qualify, not only Mississippi but other states, for additional funds to continue to build on this experience. Is this a worthwhile investment of Federal or tax- payer funds?

Mr. Beck. Absolutely, Senator. And I think the people in Mississippi should be very proud that Mississippi is one of the five that has been chosen nationally. The way that we are using this grant is different from the other four states. We are taking a much broader span of coverage than they are, a broader group of people. Not only are we looking at the elderly, but we are looking at younger people, children.

One of the tenants of public health has always been preventive medicine, preventive health. There is an issue about home health care that hasn't been spoken to, and that is one of timeliness. You see, what is happening out there, Senator, is we have a lot of people who must wait until they become sufficiently ill or disabled for the system to help them.

And basically what this project is doing is saying that is ridiculous. We are trying to intervene sometimes with nothing more than an aide care that you have heard about to help these people with their activities of daily living, which sometimes is very much more destructive to their being on their own than a medical problem, per se.

We are also trying to network with the Area Agencies on Aging, with the Meals on Wheels, with these other people. There are a lot of programs out there that are not adequately utilized because the clients do not have sufficient knowledge of them. There is not a person there that is looking after that individual person's needs that says you can get this and do that.

And we are trying to prevent deterioration. In many of these cases, including the two examples that I alluded to, really minimal expenses on the government's part is going to save them a lot of money. But more importantly, it is going to give these people the dignity that they deserve. They have been hard working citizens of this State and they are not asking very much.

I mean, in some cases someone to make sure they don't have to spend the day in their own excrement, to have a few diapers or blue pads, to have someone come out and do just some minor repairs to a bathroom so they can use their own bathroom.

You know, in the great context of the technological developments in medicine, this is kind of small. But it may be the most important.

Senator Cochran. Well, that is a very eloquent statement. And I congratulate you for it and thank you very, very much for giving us this information and letting us now about how this project is working in our State. I'm hoping that we can see more effort and more investment in the preventive health care area.

The public health service has recently come out with goals for the year 2000 in preventive health care dealing with smoking and drug abuse and alcohol abuse and proper diet and nutrition information—a lot of things that really can make us a healthier Nation, and can avoid of lot of expensive health care costs if we do the things that we ought to be doing.

And you're testifying along those same lines today, too. And I think that is something we really need to concentrate on. We had a hearing the other day in our committee with Dr. Louis Sullivan testifying, who is the new secretary of the Department of Health and Human Services. And he is very interested in this. And as a health care practitioner in his career and as an educator for Moorehouse Medical School, he was recalling for us experiences where the entire medical profession was focused on curing illness and having to concentrate on that.

Now we have some opportunities to deal with preventing people from getting sick. And that is a very important and worthwhile effort for our Federal government to be involved in now. And that is a part of what is happening here. Under this project, medical and custodial type services are both provided, as I understand it, in the home as well as various social services that end up being just as important in many cases.

Mr. BECK. Well, one of the problems that is not often given enough credence is the impact it has on the the families of these people. You know, when we look at the benefits, we say it is going to help so many hundred-thousand people. But it is many, many times that. Because trying to keep mother at home, not just the finances, it is the emotional distress that this has caused. It is seeing patients who, you know, they see mother have a change in heart beat or cough, and they don't know whether this is a life or death threatening thing or whatever.

And it just destroys these families. It breaks them up sometimes because of the financial problems. It pits one child against another for who is going to take care of it. You know, the government loves to do cost benefit analysis. I just don't know how much benefit you can put on that. I don't know how much money that is worth. It would be worth a whole lot to me.

Senator COCHRAN. That is a very good point. Mr. Greenhill, your comments were very interesting to me because they make us think about some changes in our other laws that can have impact in the health care area, particularly long-term and elderly care issues, like tax incentives to help us do things or encourage us to do things that we might ought to be doing anyhow like buying some protection now that would be a much lower cost than the benefit that will be needed later on.

What kind of products—if I were, for instance, interested in buying insurance protection now for myself or my wife, my family members—does the insurance industry now offer? Are there any that would be attractive enough to cause people to consider buying them at this time without government subsidy or do we have to have government subsidy for this?

Mr. GREENHILL. I think the tax incentive is always good. You see what it did for the IRA program by encouraging people to prepare for senior retirement. There are many companies out there today marketing long-term nursing home products that do not require hospitalization to use the benefit that offer lifetime benefits. Premiums are waived after 90 days. More companies are entering the market in offering home health care products that will pay for custodial care at home under a doctor's regular plan of care.

Again, those are things that, as far as if you've got somebody with Alzheimer's, there isn't a medical problem, per se, but they can't be left at home by themselves all day long.

Senator COCHRAN. You mentioned taxing the reserves or the premium reserves for health care insurance the same as the tax treatment is now for, what, life insurance coverage or life insurance policies. Tell me a little bit more about that and what change needs to be made.

Mr. GREENHILL. Well, I'm not an actuary. All I know is that it is more profitable to write life insurance than it is health insurance. Also, the life insurance reserves have some type of tax favored treatment where health insurance reserves do not. Or if we could provide the industry incentives and give them some tax favored treatment for reserves.

Senator COCHRAN. Is it a hard sell, too, because a life insurance policy is inevitably going to pay off? You are going to die. But you might die before you need custodial care. What happens to the benefits in those instances?

Mr. GREENHILL. If you don't use the coverage there is no benefit. However, I'm glad you brought this up because our State insurance department has a real problem with the return of premium type products. Currently the carrier I work with has a product on the shelf that would return premium if the coverage wasn't used.

And I believe we'd really be able to sell that product. Again, when convalescent care products were first introduced, we had marketers and they said it is like selling life insurance. You have to create a need, this, that, and the other. The only problem with that is is exactly as you pointed out. In life insurance sales, sure, somebody is going to die. There is going to be a need for the product eventually. Convalescent care and home health care products, again, it may not be used so there is some resistance.

One thing I'd like to point out, most of the sales that we get knocked out of on this type coverage, surprisingly it is not another agent in there doing it. It is the children of the elderly saying, "No, mom, don't worry about it. We are going to take care of you." So, I think education——

Senator COCHRAN. And then they won't answer the phone or the phone is off the hook. Well, that can be a problem. And I appreciate your making us think about this, and also the other suggestions you made, not just for insurance policies to protect against the need for this kind of thing, but the tax changes that we ought to consider.

You mentioned an entire list, and I think I would like to review that later and consider introducing legislation to make those changes in the tax code that would help us do things now that would really make less costly medical and health care expenses later on. I thought you had a list of very good suggestions.

And is that an insurance industry proposal, that list of tax changes that you——

Mr. GREENHILL. Well, I'll be honest with you. Most of these ideas were gleaned from the CEO of the insurance carrier I work with at Pioneer Life in Rockford, Illinois.

I think one thing that would really help—again we have a lot of senior Americans that, again, they don't have an earned income and they don't have nearly the discretionary income that most of us working do. The tax incentive where if I was allowed to buy a long-term care policy for my mother and deduct that premium, I think that would create a lot of incentive.

And, again, we have—a lot of the sales that we make, we have two or three children paying the premium to protect the estate and assets. If mom or dad can't pay for it, the kids can get together. It is a lot easier for them to pay that premium collectively. They could share a tax credit for that. I think we would be able to prepare for long-term care needs in the future, because they are inevitable.

Senator COCHRAN. Well, I appreciate you being here and being a part of this panel. I thought this was a good panel and very helpful.

We have two other panels we are going to hear from. But before we proceed with those other two panels, I think we will take a break and give everybody a chance to stretch a little bit. We will reconvene the hearing in 10 minutes.

[Short recess.]

Senator COCHRAN. If the hearing room will come to order we will reconvene our hearing. Before we go to our next panel of witnesses, I just want to express the appreciation of our committee for the hospitality that has been extended to us here at this very nice facility. The East Mississippi Electric Power Association has been very generous in making available its auditorium for us to have the hearing today.

We want to thank Emmett Murray, who is head of this association and manager of the Association here in Meridian, for his help in securing this facility for us. And out here at the facility Janice Heindl and Mike Reich of the staff of EMEPA have been very helpful in arranging for our hearing and in setting up and doing the things necessary to make us all comfortable here today. We appreciate their very important help.

Also, we want to thank the staff in Washington who actually run this subcommittee on a day-to-day basis, Elma Henderson, who is Senator Matsunaga's staff director. She has been very helpful in getting the full committee's approval for the hearing.

We will now bring to the witness table our fourth panel of medical professionals who will help us understand from their perspective what we need to know about the home health care needs and the medical needs of our elderly population.

We welcome to our witness table Dr. J. S. Covington, Joe Covington, who is an internal medicine specialist from Meridian, MS. He will come forward.

Mrs. Mary Stainton, who is vice-president of South Mississippi Home Health, the largest free-standing home health agency in the State. Dr. Jerald Jackson, an internist who specializes in geriatric medicine. He is currently serving as the Chairman of the Physicians Advisory Committee on Long-term Care for the Mississippi State Board of Health. And Ms. Cathy Lomax, who is a registered nurse and director of nurses at Quality Home Health in Biloxi, MS.

We are very pleased to have you all here with us today. We thank you for being here, and we ask you to proceed. I think we will go ahead and let each of you give a statement for our hearing record, and then we will have an opportunity for questions and answers.

Dr. Covington.

STATEMENTS OF DR. JOE COVINGTON, INTERNIST, MERIDIAN, MS; MARY STAINTON, R.N., VICE PRESIDENT/DIRECTOR OF NURSING, SOUTH MISSISSIPPI HOME HEALTH, HATTIESBURG, MS; DR. JERALD JACKSON, INTERNIST, HATTIESBURG, MS; AND KATHY LOMAX, R.N., DIRECTOR OF NURSES, QUALITY HOME HEALTH, BILOXI, MS

Dr. COVINGTON. Yes, sir. I have a several-page, typewritten statement that I wrote out which I will not read unless you——

Senator COCHRAN. That will be fine. We can put that statement in the record as if it has been read. And you may make whatever comments or summary statement for us here that you care to.

Dr. COVINGTON. Yes, sir. I'd like to just make some remarks sort of off the cuff.

Senator COCHRAN. That will be fine. Thank you.

Dr. COVINGTON. First, let me say about myself I've been in medical practice here in Meridian for the last 34 years and have recently semi-retired, in that I've given up office practice and am doing only nursing home patients. I have a bunch of them. So, I've had a lot of experience with them, plus some experience with the home health agency patients.

In the discussion that is going on, it certainly seems obvious that we need a great many different approaches to the care of the frail elderly. And I think this is certainly a fine movement that there are so many different possible levels, so many different needs of care depending on what the individual needs at that time.

I'd like to comment that the—I think nursing homes are here with us. And that has got to be a growing business because of the growing need for the vast numbers of elderly people. Maybe 25 or 30 percent in nursing homes could be handled in some other degree of care, maybe a lower level of care. But there is still an awful lot of people out there that we can't forget whose needs are so great, the people that are comatose even or in total vegetative states, is a crude word, that nothing else would do.

So, I don't think that all of a sudden nursing homes are going to be wiped out by whatever comes up. But certainly anybody who can be cared for at a level of care lower than that, it certainly seems appropriate, and certainly I and all of us are happy to see that so many different viewpoints are being taken toward long-term care.

Also, we must not forget that all of these folks don't just live out a nice peaceful existence and finally go to sleep when they are 90-something years old. Most of them get sick first. And a lot of them develop things that have to be taken care of, either acute problems or chronic problems. So, there is still going to be a lot of movement back and forth into the different care modalities that are needed for different people at different times.

I'll mention a personal incidence. My father had a stoke some years ago. Stayed in the hospital a long time, and then he had to go to a nursing home because he was just out of it. Well, he improved dramatically. In his case it was a private nursing home that happens to be nonprofit so that the cost was not too terribly high.

We got to figuring when he improved how much it would cost to move him back home and keep somebody with him round the clock. In my rough estimate, it would cost three times as much as keeping him in that nursing home. So, that is where he stayed. Of course, it happened to be one that I went to, so I saw him frequently. And he got very good care and unfortunately passed away later. But it was a desirable situation for him and my family.

So, personal independence and privacy and things like that, when it makes a difference, sure, let's look at it. But there are some cases it really—on medical care is what really makes a difference.

And the respite care, you know, there are some nursing homes and other facilities that are able to provide that. That has been a big boom in Meridian in the last few years. We didn't use to have anything like that. We are very happy to see that there are retirement homes and personal care homes and so on that have sprung up that can meet some of those needs.

Most of the patients that I have in nursing homes are either Medicaid so they had to meet the welfare requirement, or they are private pay. Medicare—and certainly in our experience here in Meridian in the nursing home setting, it has not been a very big aspect of that level of care.

Some patients in nursing homes come there, and they do improve, and they could move to a lower level of care. But they don't because the level of care they are at now, the skilled nursing home, Medicaid is paying for it, is what is being paid for.

If they move out of that, who is going to pay for it? They have to drop back to the resources of themselves or their family if it is there. So, this movement for help to provide some funding in some way to these people that lower levels of care of the nursing home certainly seems to deserve to be looked into, in my view.

Now, I'm going to say something that might be a little bit unpopular, might sound a little greedy or something. But in the formation of a lot of these programs, particularly home health care, we doctors were almost left out of the picture. We weren't asked very much and no provision was made for any compensation for anything that we did, as far as I have been able to determine.

You might say, well, we are all filthy rich anyway, and we don't need it. We ought to jump to the chance to be altruistic and provide some charity care and so on. But I'm afraid we don't all quite think that way. One thing I would like to suggest is that we—that that be looked at, the fact that the opinion of organized medicine has not been requested enough.

And we have not been given enough consideration into some of the planning that goes on here. After all, you know, we are supposed to be the captains of the team, so to speak, in the medical sense. And I think there is a great deal of very valuable input that could come from the medical profession if it was just asked for. And it hasn't been asked for enough.

Senator Cochran. Thank you very much. I appreciate your comments, Dr. Covington, and your being here to help us with this hearing.

[The prepared statement of Dr. Covington follows:]

PREPARED STATEMENT OF J. S. COVINGTON, M.D.

Statement of J.S. Covington M.D. in response to a request to appear as a witness at the sub committee on home health care for the elderly to be held on February 15, 1990 in Meridian MS.

For biographical information: I graduated from Medical School in 1952, took 4 years of post graduate training, and have been in the practice of Internal Medicine in Meridian since 1956. For the past 16 years I have been in a small group of internal medicine practioners. In January 1990 I retired from the office practice but am keeping my large nursing home practice for some time yet. I have patients in 5 nursing homes in various levels of care from skilled nursing care, to intermediate, and some in personal care only. I am the medical director of 2 of these, namely Kings Daughters Rest Home and Benchmark Health Care. I have no proprietary or financial interest in any facility and do not plan to have any.

In recent years my practice has leaned more toward geriatrics, so I have had many frail elderly to follow in the office, hospital, nursing homes and through home health agencies. The nursing home patients I continue to follow, including when they are hospitalized. My fairly large number of patients to be followed through H.H.A. have been turned over to my three ex-partners. Of course these patients are free to request any other doctor should they choose, but I am no longer available to them.

I have been a member of the Riley Hospital H.H.A. advisory board several years since it organized. Attending most of those quarterly meetings has given me some insight into the functions and problems encountered in running a hospital based and supported H.H.A.

About 10 years ago when I was on the Board of Turstees of the State Medical Association, we had a long discussion about H.H.A. In fact I was one of a two man committee to look into this and report to the board. I am afraid that our attitude about this aspect of medical services was largely negative at that time and I suspect that this has not changed much since then.

Now I am going to make some fairly strong statements. I will exaggerate beyond my actual personal feelings about this for the purpose of emphasizing some points that could be argueable. Fist, we medical doctors were almost left out of the planning and development of H.H.A. As far as I am aware, we had minimal input into this movement. Many physicians look upon these organizations as opportunities for entrepreneurs to promote durable equipment that is not always needed, perhaps some questionable unneeded services, high salaries for themselves, and so forth, which may not always be cost effective. There are tendencies on the part of many patients and their families to load up on expensive equipment when they leave the hopsital to have at home under the auspices of H.H.A., some of which may not be needed.

We physicians do not make many house call these days, in fact, most make none at all and do not wist to consider doing so. Yet we realize the desirability in many cases to see and attend these patients at home by someone with training and experience to help them, especially if this approach is cost effective, compared to N.H., transporting the patient to our offices or the hospital emergency rooms or other solutions. We physicians have the perogratives of prescribing medications, ordering tests, sometimes recommending hospitalization and some input into these patients' care on the basis of written reports from the R.N. who has visited in the home. Although, in some cases we would feel more comfortable and secure in our evaluation of these patients to actually see them, this approach is usually adequate. So, what is the problem from our standpoint? Talking with nurses on the phone, reading their reports, rechecking the need for medication, test and treatments, take time, thought, effort and accepting responsibility for the outcome of these patients. What do we get in return? We have the satisfaction that some trained persons are looking at these patients and reporting to us and if hospitalization is needed we are the attending physicians for which we can be compensated, but for all other involvement with these programs, we are not compensated. We physicians are thus almost forced to be altruistic, or give essentially charity care. Our time is diverted from other patient care for which we can be compensated.

If there are any provisions under the Medicare or Medicaid that allow even token compensation for this time and responsibility spent, I have been unsuccessful in finding them. Do I sound greedy? I can hardly be accused of being self-serving in this matter since I have retired from office practice and am thus rapidly discontinuing the following of these patients and doing their necessary paper work. We should think about engendering more enthusiasm from practicing physicians in home care problems other than the compensation issue. There are some problems that we physicians have already thought through or have had experience with that the nurses, acting as practioners, have to develop some expertise. An example of that would be what cultures to obtain for chronic ulcers, skin lesions, urinary infections, etc. I feel that it has been unfortunate for over-all patient care that we physicians have been involved in home health care to such a limited extent and we should have more input. I wish to present to this hearing that methods be actively sought to involve us more. We can be very responsive sometimes when asked.

As time goes on, demographic predictions are for increasing numbers of frail elderly, so we need to consider better and more cost effective ways to help these people get health care. Many people with chronic illnesses have such overwhelming problems that a nursing home is the most satisfactory solution. Most can be cared for in their own homes or retirement appartments with some supervision and other possible arrangements. Of course, peoples' needs change and some movement up or down from one type care to another may be needed to provide what that individual needs, but no more than is needed.

It is the strong opinion of many physicians that many elderly or chronically ill people are over-medicated. Further awareness of this could save some funding and yet improve health status in many frail persons. The Federal Drug Administration could perhaps help with this by tightening the indications for the use of some medications or by forcing some of these questionably effective drugs off the market.

I hope my remarks have some meaningful input into our consideration of problems of increasing medical care for the frail elderly and disabled people whom we must feel responsibility towards.

J.S. Covington, M.D.

Senator COCHRAN. We will now hear from Ms. Mary Stainton. I mentioned that she is executive vice-president of South Mississippi Home Health, which is the largest free-standing home health agency in the State. She is also on the board of directors of the American Nurses Association. She will be offering the nursing perspective as it relates to health care services. Ms. Stainton, thank you for being here.

Ms. STAINTON. Thank you. Thank you, Senator Cochran. This might shock Dr. Covington, but I have to agree with what he is saying before I go into my prepared speech.

Physicians should be compensated for the work that they do with home care. Let me explain why. When home health became an entity or component of the Medicare system back in the Sixties, it was really viewed as an add-on by many providers—physicians, nurses, hospitals.

And the physicians role was there, but it was not as a demanding role as it is now. Home care is not long-term care, and I would like to stress that. Home care is acute care. Home care as defined under the Medicare program is acute care.

Now, we do see some chronically ill individuals who are requiring a skill which makes them eligible for Medicare benefits, the home care benefits under Medicare. But what nurses are doing in the homes now are high tech procedures. We cannot do that without direct contact, a lot of contact, with the physicians. We are doing procedures in the home that used to be the domain of the acute care hospitals, of the intensive care unit. We are doing central lines, peripheral lines, we have hyperalimentation going in the homes now. We give an IV antibiotic, pain control pumps. You just name it and we have got it out there in the home. We are giving blood transfusions in the home.

So, what we see is a very acutely ill patient requiring a lot of contact between nurses and physicians. Physicians are receiving no renumeration for their work with us in home health. This has been something that our company has being working with on the National Home Care Association for some time.

This is the first year that the National Home Care has it on their legislative agenda to come to Congress and stress the importance of some type of compensation for physicians and in referring patients to home care. It cannot come through the home health agency because of the connotation of kick-back and all those laws that are out there. It has got to come directly from the physician to the State intermediaries or whatever. But it is a grave concern.

Now I'll get into my prepared text. Thank you for bringing that up, Dr. Covington.

My comments will focus upon the need to develop a comprehensive long-term care policy for the chronically ill and others who have ongoing needs, as well as the role of nurses in the delivery of cost-effective, innovative, long-term, and social services.

The most conspicuous deficiency in our nation's health care system is the lack of a comprehensive and coordinated long-term care benefit designed to meet the needs of the chronically ill. Ever since the enactment of Medicare, Federal policymakers have focused upon the provision of acute health care services.

Demographic patterns portray our society as an aging Nation. As our population ages, health care needs increase. The health care needs of the elderly have shifted. Most of those who have needs for long-term care suffer from chronic illnesses rather than those which are acute. These have been borne out by several recent studies on the health care status of Americans.

The delivery of health care has drastically changed during the past ten years. Decreased hospital stays, advancement in medical technology which sustains life, and the emphasis on preventive and home and hospice care all reflect the changes in the delivery of health care that we have witnessed over the past 10 years.

Health care costs continue to grow in an unacceptable rate far in excess of the growth of economy in general. These budgetary trends, in conjunction with the compelling need for the services, substantiate the need for the development of long-term care policies which incorporate efficient management practices and cost-saving measures.

For the most part, our Nation's health care delivery system focuses upon the financing and provision of acute care services. Acute care services are an essential and vital component to any health care delivery system. However, they have been created, in part, at the expense of the chronically ill. According to some estimates, upwards of 8 million Americans need some help with management of activities of daily living.

I do not contend that it is the role of the government to provide all these services to those who need them. The shear size of this estimated population commands attention of our policymakers to examine all possible options.

I would like to talk about some policy considerations. Cost: In addition to the institutional hesitancy to develop a comprehensive long-term care plan, we are cognizant of the fact that health care policy in our Nation today is a matter of budget policy. The fact that this seemingly endless strain on our national budget has compelled lawmakers to look at proposals which increase our level of Federal spending on health care services with skeptical eye.

Few can argue successfully with the fact that we are currently working with an economic atmosphere that forces legislators to operate with fiscal restraints. Therefore, it becomes incumbent on policymakers to look at recording our health care priorities, rather than developing—excuse me, reordering health care priorities rather than developing new services or delivery models which would further exacerbate our Federal deficit.

Administration: Currently Medicaid, the jointly funded, Federal/state program that provides institutional care for the chronically ill elderly is the only national program that offers long-term care to eligible beneficiaries. However, Medicaid benefits are only made available after the individual beneficiary impoverishes himself to meet eligibility requirements.

Such an erroneous requirement reflects the enormous deficiency in our long-term health care policies, which in effect erects the ultimate barrier to care.

Financing: In developing any health care delivery system, the mechanism of financing is of paramount importance. Because the cost of providing long-term care is expected to be high, it is incumbent on policymakers to examine various financing alternatives and to explore innovative methods of cost-spreading that involve the private as well as the public sector. Any financing scheme for long-term care must not only be actuarily sound, but also equitable to the general population and to the beneficiaries.

Scope: An effective long-term health care policy must define what services will be included to serve beneficiaries' needs, and how services may be delivered, and by whom. The phrase "long-term care" embraces a wide array of medical, nursing, and social, personal, and supportive services that are required by individuals who have lost some capacity for self-care.

Current role in nursing in long-term care: Nursing's role in the provision of long-term care has traditionally been strong. The vast majority of long-term care services are provided in our nation's nursing homes. Naturally, these facilities are staffed most exclusively by RN's and para-professional nursing personnel.

Another primary component of our current long-term care, as well as acute care delivery system, is home health and hospice care. Here, too, nurses are often the primary caregivers and also serve to a great extent as the coordinators of care. Medicare requires that home health agencies be managed by either a physician or licensed registered nurse. Again, this recognition is the value of the professional nurse in this setting compels the utilization of the cadre of health care professionals in both the provision and management of these services.

Finally, nurses often function as case managers in the delivery of long-term care. Long-term care regardless of the setting in which it is provided, represents a wide range of services that address the health, social, and personal care of the individuals who, for one reason or another, have developed or have lost some capacity for self-care.

While the utilization of nurses as case managers is by no means novel, it is a concept that has only begun to enjoy the implementation in the long-term care setting.

I have four policy recommendations: No. 1, establish and adopt a multilevel, long-term care system that recognizes the varying levels of needs of the chronically ill and provide for a continuation of care;

Incorporate a mechanism in the long-term health care policy which utilizes registered nurses as primary coordinators of a case management system;

Three, provide eligibility criteria which allows patients options or alternatives to institutional care;

And, four, adopt a financing mechanism for long-term care which is equitable to the general population and to the beneficiaries.

The testimony here today calls for not an expansion of services, but rather for a new means of administering existing health and social problems to those who are in need of such services. Nursing is firmly committed to the concept of implementing nursing case management programs which will provide a cost-effective, high quality, efficient means of ensuring that beneficiaries would receive adequate services to assist them with their activities of daily living and meet the demands of the established policies.

Thank you, Senator Cochran, for allowing me to present my views.

Senator COCHRAN. Thank you, Ms. Stainton, for your testimony. It is very the helpful and we appreciate very much your being with us here today.

[The prepared statement of Ms. Stainton follows:]

PREPARED STATEMENT OF MARY STAINTON, R.N

Senator Cochran, I am Mary Stainton, R.N., C., M.S. , Executive Vice President of South Mississippi Home Health, on the Board of Directors of the Mississippi Home Health Association and on the Board of Directors of the American Nurses' Association. Thank you for asking me to present testimony today.

My comments will focus upon the need to develop a comprehensive long-term health care policy for the chronically ill and others who have ongoing needs, as well as the role of nurses in the delivery of cost-effective, innovative long-term health and social services.

THE PROBLEM

The most conspicuous deficiency in our nation's health care system is the lack of a comprehensive and coordinated long-term care benefit designed to meet the needs of the chronically ill. Ever since the enactment of Medicare, federal policy makers have focused upon the provision of acute health care services.

Demographic patterns portray our society as an aging nation. As our population ages, health care needs increase. Secondly, the health care needs of the elderly have shifted; most of those who have needs for long-term care suffer from chronic illnesses rather than those which are acute. This has been borne out by several recent studies on the health care status of Americans. Thirdly, the delivery of health care services has changed drastically during the past ten years. Decreased hospital length of stay, advancements in medical technologies which sustain life, and the emphasis on preventive, home and hospice care all reflect changes in the delivery of health care that we have witnessed over the past ten years. Lastly, health care costs continue to grow at unacceptable rates, far in excess of the rate of growth in the economy in general. In 1965, when Medicare and Medicaid became law, the nation spent only $41.9 billion on health, equal to 5.9 percent of the Gross National Product. The Health Care Financing Administration (HCFA) projects that spending for existing health programs will exceed $1.5 trillion by the year 2000.

These budgetary trends, in conjunction with the compelling need for the services substantiate the need for the development of long-term care policies which incorporate efficient management practices and several cost-saving measures.

For the most part, our nation's entire health care delivery system focuses upon the financing and provision of acute care services. Acute care services are an essential and vital component to any health care delivery system. However, they have been created in part at the expense of the chronically ill. According to some estimates, upwards of eight million Americans need some help with managing the activities of daily living. I do not contend that it is the role of the government to provide all services to those who need them, the sheer size of this estimated population commands the attention of our policy makers to examine all possible options.

The continued focus on acute care policies reflects the linear development of our federal health care laws, beginning in 1964 with the enactment of Medicare and Medicaid. However noteworthy, this body of law has not undergone a comprehensive review to examine and modify the benefits to meet current needs. Our society's perception that health care is a right of citizenship has successfully compelled politicians to increase their support for the continuation of these programs. However, it is time to reexamine our health care priorities and initiate necessary policy changes.

POLICY CONSIDERATIONS

Cost. In addition to the institutional hesitance to develop a comprehensive long-term health care plan, we are cognizant of the fact that health care policy in our nation today is a matter of budget policy. It is estimated that our nation currently spends twelve percent of its gross national product on health care services. Total expenditures equal $244.3 billion, which represents a $1,721 per capita expenditure (1985 data). Of these amounts, $35.2 billion accounted for nursing home care. Clearly, this represents a staggering investment in our health care delivery system. More importantly, however, is the fact that this seemingly endless drain on our national budget has compelled lawmakers to look at proposals which increase our level of federal spending on health care services with a skeptical eye. Few can argue successfully with the fact that we are currently working within an economic atmosphere that forces legislators to operate with fiscal restraint. Therefore, it becomes incumbent upon policy makers to look at reordering our health care priorities, rather than developing new services or delivery models which would further exacerbate our federal deficit.

Administration. Currently, Medicaid, the jointly funded, federal/state program that provides institutional care for the chronically ill elderly, is the only national program that offers long-term care to eligible beneficiaries. However, Medicaid benefits are only made available after the individual beneficiary impoverishes himself to meet eligibility criteria. Such on onerous requirement reflects the enormous deficiencies in our long-term health care policies, which in effect erects the ultimate barrier to care.

Financing. In developing any health care delivery system, the mechanism of financing is of paramount importance. Because the cost of providing long-term care is expected to be high, it is incumbent upon policymakers to examine various financing alternatives and to explore innovative methods of cost-spreading that involve the private as well as the public sector. Any financing scheme for long-term health care must not only be actuarily sound, but also equitable to the general population and to beneficiaries.

Scope. An effective long-term health care policy must define what services will be included to serve beneficiaries' needs, how such services may be delivered, and by whom. The phrase "long-term care" embraces a wide array of medical, nursing, social, personal, and supportive services that are required by individuals who have lost some capacity for self-care. Emphasis should be placed on efficiency in the delivery of services utilizing innovative concepts, such as the de-institutionalization of individuals who, with the proper management of their health and social needs, could continue to reside in their communities. The coordination of these health and social services could be provided by nursing case managers to meet the needs of these individuals.

There are many other factors that must be considered in developing a comprehensive effective, and efficient long-term health care policy. Such policy considerations should focus on providing the most flexible program possible, while ensuring the highest quality and widest range of services for those in need of long-term care.

CURRENT ROLE IN NURSING IN LONG-TERM CARE

Nursing's role in the provision of long-term care has traditionally been strong. The vast majority of long-term care services are provided in our nation's nursing homes. Naturally, these facilities are staffed almost exclusively by registered nurses and para-professional nursing personnel. Current Medicare law for skilled nursing facilities only requires that a physician visit a resident once every sixty days, after the first ninety days of residency. Medicaid law, which applies to the majority of nursing home residents, requires that the resident's physician see the resident every ninety days. The timetables established by these laws acknowledge the limited role the physician plays in the day-to-day provision of long-term care services, and supports the contention that, for the most part, long-term care is nursing care.

Another primary component of our current long-term care delivery system is home health and hospice care. Here too, nurses are often the primary care giver and also serve to a great extent as the coordinator of care. Medicare requires that home health agencies be managed by either a physician or a licensed, registered nurse. Again, this recognition of the value of the professional nurse in this setting compels the utilization of this cadre of health care professionals in both the provision and management of these services.

Finally, nurses often function as case managers in the delivery of long-term health care. Long-term care, regardless of the setting in which it is provided, represents a range of services that address the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self-care. By definition, this population is best served by professional nurses who, by virtue of both their academic as well as clinical education are best prepared to address the multitude of needs of this particular patient population. Nurse case managers not only focus upon health maintenance, disease prevention, and health promotion, but also upon coordinating care with other professional members of the health care team.

Often, the coordination aspects of the nurse case manager can result in more cost-effective care.

While the utilization of nurses as case managers is by no means novel, it is a concept that has only just begun to enjoy implementation in the long-term care setting.

POLICY RECOMMENDATIONS

The following are recommendation's to develop a policy on long-term health care:

1. Establish and adopt a multi-level, long-term care system that recognizes the varying levels of needs of the chronically ill and provides for a continuation of care.

The medical focus of our current health care policies generally reflects an episodic approach to health care delivery rather than a system designed to follow a continuum. Such an approach is best suited to the provision of acute care rather than long-term care services. Nursing, throughout its history has promoted the philosophy of continuity of care. This reflects a belief that all health care services should be comprehensive, rather than episodic.

2. Incorporate a mechanism in the long-term health care policy which utilizes registered nurses as primary coordinators of a case management system.

The case management system has proven to be a useful means with which to effectively allocate scarce resources in an efficient manner. Many elements comprise the case management system. Health assessment; the subsequent planning of services; the procurement, delivery, and coordination of services; and finally, the monitoring of the effectiveness of these services to meet the needs of the beneficiary are all combined to efficiently address and provide all of the services necessary to assure a high level of care to the client along a continuum.

The implementation of a comprehensive case management system would not be a new approach to service delivery. In the 1971 Social Security Amendments Section 1115 provided for home and community-based waivers that allowed States to provide federally-mandated Medicaid services on an outpatient basis. This trend continued for Medicare programs under provisions of Section 222 of the 1972 Social Security Act Amendments. The federal government continued to demonstrate their support for this trend with the establishment of 13 community-based long-term care demonstration sites called, "channeling projects" in 1980. Individual states and municipalities have demonstrated their support for the case management concept with the establishment of the Georgia Alternative Health Services Program, the Wisconsin Coordinated Care for the Elderly program, the Washington Community-Based Care for the Functionally Disabled, the New York Long-Term Home Health Care program, and the On Look Community Care for Dependent Adults program in San Francisco, California.

Interestingly, the stricter budgetary limitations imposed upon individual states have compelled their further interest in providing managed care. Deficit spending is not an option for most State Governors. Subsequently, the individual States are forced to identify the most cost-effective means necessary to provide federally and state-mandated services to their beneficiaries. Case management has proven, for them, to meet this important objective.

In summary, the incorporation of professional nurses in the care and management of long-term care will promote the most efficient utilization of the nation's largest group of health care providers.

3. Provide eligibility criteria which allow patients options or alternatives to institutional care.

Shift from institutional long-term care to home and community-based long-term care services is evident. Legislative proposals are needed that would offer providers, beneficiaries and insurers options to institutional health care delivery. The creation of a multiple-level, long-term health care delivery system which would offer beneficiaries access to a broad and appropriate range of services, either in their homes, a walk-in clinic, a community facility, or within an institution is the key to the successful application of the vast array of health care services associated with any such delivery system is that the beneficiary receive all necessary services in the most cost-effective and least restrictuve setting as possible.

We also urge the incorporation of provisions to ensure universal access for all Americans who are in need of these services which will enable them to be eligible for these programs regardless of the individual's ability to pay. Eligibility for beneficiaries should be based upon functional disability rather than specific illness.

While it is true that the Medicare program offers some home health care benefits, the qualification criteria established for these benefits, as well as budgetary limitations on this program, prevent it from being inclusive and long-term in nature. In fact, the eligibility criteria for any long-term care benefit must be reviewed in order to assure that access to the proposed service relates to the actual need. Currently, eligibility is determined by a physician who makes determinations in conjunction with statutory limitations defined in law. Such subjective evaluation criteria rely upon evaluations made by physicians, usually in conjunction with a medical diagnosis. Because chronic ailments do not necessarily involve medical problems, the development of other eligibility criteria is necessary.

4. Adopt a financing mechanism for long-term care which is equitable to the general population and to beneficiaries.

Of paramount concern is the potential impact the development of any long-term care policy may have upon the federal deficit. Financing could arise from a reordering of existing priorities for the funding of federal programs. Protection for the low and moderate income beneficiary must be included in the structure of co-payments, deductibles, and premiums associated with the programs proposed. Whatever financing is recommended, it must be adequate to minimize the financial impact upon the individual.

SUMMARY

The testimony today calls not for an expansion of services, but rather for a new means of administering existing health and social programs to those who are in need of such services. Nursing is firmly committed to the concept of implementing nursing case management programs that would provide a cost-effective, high quality, efficient means of ensuring that beneficiaries would receive adequate services to assist them with their activities of daily living, and meet the demands of the established policies.

Thank you for this opportunity to present my views before this hearing.

Senator COCHRAN. Our next witness is Dr. Jerald Jackson who is from Hattiesburg. He is a specialist in geriatric medicine and internal medicine. He is currently serving, as I said in the introduction of the panel, as Chairman of the Physicians Advisory Committee on long-term care for the Mississippi State Board of Health. He is also involved in providing care through the Medicaid home and community based waiver program.

We are glad you are here, Dr. Jackson. You may proceed.

Dr. JACKSON. Thank you Senator Cochran. Today them, tomorrow thee and me. Long-term care is a fairly simple concept. Persons who require long-term care most often do so because they can no longer perform the activities of daily living or they have a cognitive problem.

Historically, we have treated chronic, long-term impairments as medical problems for which we have relied upon nursing homes to provide the primary care. But the demographics of our aging society is imperative, and options outside the nursing home must be developed.

The general consensus is that any viable long-term care system must have three components which must be available in sufficient numbers to meet the needs of the long-term care population. These components are a home care program which provides a wide array of services, a housing program which provides the same services that are available in the home care program, a nursing home program which provides services to those most impaired and those with complex medical problems.

In February 1990, if you're old, if you are poor, if you need long-term care in Mississippi, you are most likely headed for a nursing home. The weakest aspect of our long-term care system is its heavy dependence on nursing homes to provide the majority of long-term care and its lack of a viable, nonmedical housing options for the functioning impaired elderly.

For example, Mississippi invests 96.9 percent of its Medicaid funds for long-term care in its nursing homes. Furthermore, Mississippi has invested heavily in long-term care services in the medical model of nursing homes and home health care which assumes that most long-term care clients need medical care.

On the other hand, around the country 10 to 15 percent of long-term care clients need complex medical treatment, while 50 to 60 percent need routine medical care such as medication management. Thus most states provide routine medical care not through a nursing home or home health option. Rather, such services are provided in various alternate settings such as personal care homes or adult foster homes.

In 1985, the Mississippi Legislature authorized a pilot program for the Federal 26 Medicaid Home and Community Based Waiver in Lafayette and Forrest Counties for 100 recipients at each site with 2 locations added later. The obtuse manner by which it was implemented and administered makes any meaning conclusion about its impact or success impossible.

Unfortunately, the question of whether the 2,176 Waiver services are utilized as a substitution for nursing homes or in addition to nursing homes, or whether it will be cost effective, cannot be answered with any degree of accuracy with current data and current procedures for determining 2,176 Waiver clients. Conceptually such services should be of great benefit, especially if Mississippi chooses to invest in nonmedical housing options.

Our traditional health care system is focused on acute care services while the health needs of the elderly population is beset by problems of a chronic nature. Primary treatment of the elderly in acute care settings is frequently not cost effective, and does not allow for a range of chronic care services that would be of most benefit to the elderly. Yet, to provide quality chronic care is no less important or less complex than to provide quality, emergency, or acute care.

In Mississippi, home health care is the primary noninstitutional service for persons requiring long-term care. Most States have moved away from home health as a long-term care program because of its high unit cost and because it is essentially an acute medical service which is not designed to provide cost effective care to the chronically impaired.

Mississippi home health agencies report that half of all clients and half of all visits are for home health aid. Somehow I fail to see the logic of having a nurse assess a home situation where the most important service provided is that of an aide. One must question whether such alternative such as private duty nurse or personal care options such as utilized in other States might be a more cost-effective, viable option.

As all of you are perhaps aware, there is no reimbursement to physicians in the home health program. Rather, we have been relegated to a role in the system where our major rewards are numerous phone calls, reams of patients—reams of paper requiring our signature, and "boiler-plate" computer print-outs for services rendered for that month.

What I'm getting to is that there must be a major restructuring of home health services being rendered. Case management, perhaps along the lines of the community waiver program, should be an integral part of services available to the elderly patients so that the total socio-economic, psychological, and functional State of the individual is considered initially and reassessed periodically.

Because physicians have been excluded from the bulk of decision making in home health, I will make a strong plea that formal geriatric training with perhaps certification be required for nurses. I envision where a patient might be seen, examined, have a functional assessment, medications reviewed, and appropriate therapy instituted by a geriatric practitioner.

Such an approach when it is integrated with other community services is not the "Holy Grail," yet it may well be cost effective and efficient for the frail elderly who wish to remain at home or in their community.

To provide quality care to the elderly, one must consider all available health related resources when assessing needs in developing care plans. As a physician for 25 years, I remain appalled at the fragmentation and lack of coordination of services which exists at every level that services are rendered.

For example, in 1982 we compiled a compendium of "Health Related Resources for the Elderly" which listed 20 categories of services and resources from 75 different entities available for the elderly in our community. Today there are over 5 organizations offering such services in our community today.

Again, I wish to propose that identification of health related services be developed in every community across the State and country. A designated entity should catalog the various services so that all health providers and potential recipients—that is, the elderly—might simply be able to know what services are available where at home.

Next, one like might logically think that similar and duplicated services in different agencies would be evaluated so that the most efficient, cost-effective system would evolve tailored to the needs of every individual and not to the needs of each little tea-pot bureaucracy.

The essence of geriatric practice is expert management of a patient's needs. Realistic chronic care is based on a knowledge of an individual's functional abilities, social supports, psychological State, and personal preferences to establish appropriate goals and expectations.

About 2 years ago we established a geriatric team consisting of persons interested in evaluating and managing dilemmas posed by the elderly patients. This team has evolved into physicians, social workers, nurses with an interest in geriatrics, a physical therapist, a dietitian, and nurses from home health agency.

When a referral to the geriatric evaluation team is made, each discipline reviews the patient from their professional perspective against a list of options that are available in our community. Weekly the teem meets so that a member of each discipline can provide their recommendations to the geriatric team summary which then is given to the primary physician, nursing home, home health agency, and ideally to the patient's family and caregivers.

We feel that we are demonstrating benefits and outcomes as shown in other geriatric assessment programs which include improved diagnosis, improved placement location, improved functional status, reduced prescribed medication, decreased nursing home use, increase use of home health services, reduced use of acute hospitals, reduced medical costs.

Just as the CAT scanner was the high-tech innovation of the Seventies, comprehensive functional assessment of the frail, elderly individual coupled with a knowledge of community resources may well prove to be the low-tech innovation of the Nineties for long-term care.

I'd like to say that last evening just as I left the office, my last phone call going out the door was to some home health nurse about a little 88-year-old black lady who has had strokes, intermittently confused, medication and breathing problems, lung problems, and great problems with constipation. Again, not an unusual problem.

But this patient's caregiver is an only son who is single. And basically the question from the nurse was "can I draw some lab work?" I shook my head. Why? Well, the visits are up. Hopefully through you and your committee, when she comes in later on this week, I can say, "Ma'am, the reason is—" questions?

Senator COCHRAN. Thank you very much, Dr. Jackson. A very graphic description of some of the problems and the challenges facing us in an effort to find more reasonable and sensible programs that can provide benefits to those in our elderly population who need medical care.

Thank you very, very much.

[The prepared statement of Dr. Jackson follows:]

PREPARED STATEMENT OF JERALD JACKSON, M.D.

Long term care is a fairly simple concept! Persons who require long term care most often do so because they can no longer perform one or more activities of daily living (such as bathing, dressing, eating, toileting, ambulating, or medication management) or have a cognitive problem. Historically, we have treated chronic long term impairments as medical problems for which we have relied upon nursing homes to provide the primary care. With the demographics of our aging society it is imperative that options outside the nursing home must be developed. The general consensus is that any viable long term care system must have three components, which must be available in sufficient numbers to meet the needs of the long term care population. These components are:

- o A Home Care program which provides a wide array of services
- o A housing program which provides the same services that are available in the Home Care program
- o A Nursing Home program which provides services to those most impaired and those with complex medical problems.

Rosalie Kane, M.D., of the University of Minnesota makes the point: "Long term care consists of those personal care and supportive services needed to compensate for functional limitation.... the long term care services themselves are often Unspecialized and Untechnical. The functional impairments of older people can be divided into those affecting the ability to do basic Personal Care, and those affecting the ability to Manage a Household."

In February, 1990 if you are old, if you are poor, and if you need long term care in Mississippi, you are most likely headed for a Nursing Home. The weakest aspect of our long term care system is its heavy dependence on Nursing Homes to provide the majority of long term care and its lack of a viable non-medical housing option for the functional impaired elderly. For example, Mississippi invests 96.9% of its Medicaid funds for long term care in its nursing homes. Furthermore, Mississippi has invested heavily in long term care services in the medical model of Nursing Homes and Home Health which assumes that most long term care clients need medical care. Around the country 10 to 15% of long term care clients need complex medical treatment while 50 to 60% need routine medical care such as medication management. Thus most states provide routine medical care not through a Nursing Home or Home Health option; rather, such services are provided in various alternative settings such as Personal Care Homes or Adult Foster Homes.

People enter nursing homes for three reasons: Either they require complex medical attention, are too impaired for most alternative services, or they can no longer stay at home and require a housing option. The Housing option with services is usually required not because a person has necessarily become more impaired, but most often because they require night-time care, 24 hour supervision or more than intermittent services. If there is no viable housing option available, such people will most likely move to a nursing home.

HOME AND COMMUNITY BASED WAIVER

In 1985 the Mississippi Legislature authorized a pilot program for the Federal 2176 Medicaid Home and Community Based Waiver in Lafayette and Forrest counties for 100 recipients at each site with two locations added later. Services offered through the Waiver program include:

- Case Management
- Adult Day Care
- Home Health beyond the 50 visit limit
- Respite Care
- Homemaker

The obtuse manner by which it was implemented and administered makes any meaningful conclusion about its impact or success impossible. Unfortunately the question of whether the 2176 Waiver services are utilized as a substitution for Nursing homes or in addition to Nursing Homes or whether it will be cost effective cannot be answered with any degree of accuracy with current data, and current procedures for determining 2176 Waiver clients. Conceptually, such services should be of great benefits especially if Mississippi chooses to invest in non-medical housing options.

HOME HEALTH CARE

Our traditional health care system is focused on acute care services while the health needs of the elderly population is beset primarily by problems of a chronic nature. Primary treatment of the elderly in acute care settings is frequently not cost effective, and does not allow for a range of chronic care services that would be of most benefit to the elderly. Yet, to provide quality chronic care is no less important or less complex than to provide quality emergency or acute care.

In Mississippi Home Health Care is the primary non-institutional service for persons requiring long term care. Most states have moved away from Home Health as a long term care program because of its high unit cost and because it is essentially an acute medical service which is not designed to provide cost effective care to the chronically impaired. Mississippi Home Health agencies report that half of all clients and half of all visits are for Home Health Aide. Somehow I fail to see the logic of having a nurse assess a home situation where the most important service provided is that of an aide. One must question whether other alternatives such as Private Duty Nurse or Personal Care options such utilized in other states might be a most cost efficient viable option.

If Home Health Care is to serve the elderly population in a cost effective manner, I would propose several major changes. Today, a Home Health nurse can visit a patient at their home and their agency can bill 3 to 4 times amount that it would have cost you and I as taxpayers had the patient visited me in my office. As all of you are perhaps aware there is no re-imbursement to physicians in the Home Health programs; rather, we have been relegated to a role in the system where our major rewards are numerous phone calls, realms of paper requiring our signature and "boiler-plate" computer print-outs of services rendered for that month. What I am getting to is that there should be a major re-structuring of how Home Health services are rendered.

Case management, perhaps along the lines of the Community Waiver program, should be an integral part of services available to the elderly patients so that the total socio-economic, psychological and functional state of the individual is considered initially and reassessed periodically. Because physicians have been excluded from the bulk of decision-making in Home Health, I will make a strong plea that formal geriatric training with perhaps certification being mandatory be required for nurses and especially nursing supervisors. Today, geriatric practitioners in other parts of the country are the role model which I envision where a patient might be seen, examined, have a functional assessment, medications reviewed and appropriate therapy instituted. Such an approach when it is integrated with other community services is not the "Holy Grail"; yet, it may well be cost effective and efficient for the frail elderly who wish to remain at home or in their community.

PROPOSAL: A SENSIBLE APPROACH TO THE LONG TERM CARE PROBLEM

Let us Discover What We Already Have

To provide quality chronic care to the elderly, one must consider all available health-related resources when assessing needs and developing care plans. As a physician for 25 years I remain appalled at the fragmentation and lack of coordination of services which exist at every level that services are rendered. For example, in 1982 we compiled a compendium of "Health Related Resources for the Elderly" which listed twenty categories of services and resources from 75 different entities available for the elderly in our community (see Appendix I). Besides hospitals, clinics, and pharmacies activities there are over 125 organisations offering services in our area today.

Again, I wish to propose that identification of health related services be developed in every community across the state and country. A designated entity should catalogue the various services so that all health providers and potential recipients -- i.e. the elderly -- might simply be able to find the services available. Next, one might logically hope that similar and reduplicated services in different agencies would be evaluated so that the most efficient, cost-effective system would evolve tailored to needs of every individual and not to needs of each little "tea-pot bureaucracy".

Geriatric Assessment

The essence of geriatric practice is the expert management of a patient's needs. Realistic chronic care is based on a knowledge of an individual's functional abilities, social supports, psychological state, and personal preferences to establish appropriate goals and expectations. To address the multiple problems, an array of health care professionals is necessary to provide comprehensive assessment and therapeutic planning. The geriatric evaluation is an interdisciplinary function with a team comprised of professionals with knowledge, skill and interest in geriatric care.

About two years ago at Forrest General Hospital we established a Geriatric Team consisting of persons interested in evaluating and managing dilemmas posed by the elderly patients. This team has evolved into physicians, social workers, nurses with an interest in geriatrics, a physical therapist, a dietician, and nurses from a Home Health agency. When a referral to the Geriatric Evaluation Team is made, each discipline reviews the patient from their professional perspective against the list of options that are available in our community. Weekly the team meets so that a member of each discipline can provide their recommendations to "Geriatric Team Summary" which may go to the primary physician, a Nursing Home, a Home Health agency, and ideally to the patient's family or caregivers.

We feel that we are demonstrating benefits and outcomes as shown in other Geriatric Assessment Programs which include:

- improved diagnoses
- improved placement location
- improved functional status
- reduced prescribed medications
- decreased nursing home use
- increased use of home health services
- reduced use of acute hospitals
- reduced medical care costs

Just as the CATT scanner was the "high tech" innovation of the 70's, comprehensive functional assessment of the elderly individual coupled with a knowledge of community resources may well prove to be the "low tech" innovation of the 90's for long term care.

Appendix 1

Outline of Community Resources for the Elderly Individual (abridged listings)

- Information and Referral Centers
    - Hospital Social Work Departments
    - Senior Citizens Agency
    - United Way
- Nursing Homes
- Home Health Agencies
- Health Department
- Rehabilitation Centers
- Medical Appliances
- Oxygen and Respiratory Care
- Nutrition
- Transportation
- Housing
- Income
- Personal Services
    - Welfare Department
    - Nurse's Registry
- Mental Health Services
- Legal Services
- Health Education
    - Hospital Community Education Programs
    - American Cancer Society
    - Arthritis Foundation
- Senior Citizens Organizations
    - American Association of Retired Persons
- Health Insurance
    - Medicare
    - Medicaid
- Veteran Benefits

Senator COCHRAN. Ms. Lomax, we are glad to have you. Ms. Lomax is a person who has had home health care service experience as a director of nursing for the Quality Home Health Care Facility in Biloxi, MS. We are glad you are here. We thank you for being a part of this panel. You may proceed.

Ms. LOMAX. Thank you. Long-term care is one of the most controversial issues related to our aging population. Long-term care consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals who have chronic, physical and/or mental impairments in a variety of institutional and noninstitutional health care settings including the home with the goal of promoting the optimum of physical, social, and phsycological functioning.

That definition refers to the chronicity which characterizes most of the ailments of older people. The impairments cannot be cured. Therefore, the services must be sustained, not simply provided for a limited time and then withdrawn as with an acute illness. The goal in planning for long-term needs is to develop what is called a continuum of care; that is, a wide spectrum of services and facilities to meet the diverse, long-term needs of our aging population.

Adult day care centers and respite services are key components of this continuum which supports the family and prevents institutionalization. Full development of community support would enable many older people who are cared for in the home to live at higher levels of health and maximum well-being. All available information underscores the central importance of focussing services on the family to strengthen its caregiving capacities and to prevent severe stress.

A delicate issue involves the determination of the point at which caregiving becomes counterproductive by causing family breakdown. Most older people who receive care at home receive it from a household member, and most receive it for long periods of time.

Family members give 80 percent of the medically related and personal care of the chronically, limited elderly. And one-third of the recipients need constant rather than partial or intermittent care. Community services are sorely needed not only to supplement and strengthen the family's capacity to care for dependent older people, but also to substitute for family care when there is no family. Thank you.

[The prepared statement of Ms. Lomax follows:]

PREPARED STATEMENT OF MS. LOMAX

In order for home health aide services to be a Medicare covered service, the beneficiary must meet the qualifying criteria:

One. Must be homebound.

Two. Under a physicians plan of care.

Three. Need skilled nursing care on an intermittent basis or physical therapy, speech therapy or continued need for occupational therapy.

CASE STUDY

The physician orders home health aide visit to a stroke patient who has right side weakness and poor endurance. The patient suffered the stroke 3 years ago and has no other health problems. The beneficiary lives with an elderly frail sister who is disabled and who cannot perform either the personal care or the incidental tasks.

The beneficiary would not be eligible for Medicare benefits under guidelines defining skilled care; therefore, home health aide visits cannot be covered.

Long-term care is one of the most controversial issues related to our aging population. Long-term care consists of those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive and maintenance services for individuals who have chronic physical and/or mental impairments in a variety of institutional and noninstitutional health care settings, including the home, with the goal of promoting the optimum of physical, social and psychological functioning.

That definition refers to the chronicity which characterizes most of the ailments of older people. The impairments cannot be cured. Therefore, the services must be sustained, not simply provided for a limited time and then withdrawn, as with an acute illness.

The goal in planning for long-term needs is to develop what is called a "continuum" of care—that is, a wide spectrum of services and facilities to meet the diverse long-term needs of our aging population. Adult day care centers and respite services are key components of this continuum which supports the family and prevents institutionalization.

Full development of community support would enable many older people who are cared for in the home to live at higher levels of health and maximal well being.

All available information underscores the central importance of focusing services on the family to strengthen its caregiving capacities and to prevent severe stress. A delicate issue involves the determination of the point at which such caregiving becomes counterproductive by causing family breakdown. Most older people who receive care at home receive it from a household member, and most receive it for long periods of time. Family members give 80 percent of the medically related and personal care to the chronically limited elderly, and one-third of the recipients need constant rather than partial or intermittent care.

Community services are sorely needed, not only to supplement and strengthen the families capacity to care for dependent older people, but also to substitute for family care when there is no family.

Senator COCHRAN. Thank you very much, Ms. Lomax. I think I have been going back to the beginning and asking questions and going back to the last witness. I'm going to go the other way this time just to confuse everybody, or confuse myself.

Ms. Lomax, you, of course, are experienced in trying to recruit and manage people who provide these services at Quality Care in Biloxi. Do you have any difficulty attracting people to this profession? To get people to work in this setting in this environment?

Ms. LOMAX. Yes, that seems to be a problem getting nurses with the nurses shortage. Home health requires a lot of paperwork. There is a mound of paperwork. We have been accused of having three forms to say one thing throughout the years of my doing home health.

I have worked in an acute setting. I have worked in a long-term facility, and I've also worked in home health. So, I consider myself well versed in all aspects of general nursing.

When I first started in home health, I was on the road. I had a case load, and I went into the homes, and I saw my patients and took care of their needs. I believe in home health. I have seen other aspects of patient care, and I feel that home health is quite beneficial to the patients. It keeps them out of the hospital.

A lot of times when patients really need to go to the hospital they don't want to go. They will say—we'll suggest that they go to the emergency room for evaluation by a physician, they don't want to go because they say "if I go, they will keep me."

Senator COCHRAN. When we talk about case management—that is something Ms. Stainton mentioned and we had other witnesses today talk about case management—is it your opinion, too, that we need to have a medical professional in charge of case management for those who need home health care services?

Ms. LOMAX. Absolutely. There have been other states that have done case management. One of my nurses that just came to work with me worked on a committee in Hawaii. That was one of her functions. She went into the home and evaluated the situation for patient's needs and made decisions working directly with her other fellow workers. And they had very good luck with it.

Senator COCHRAN. Dr. Jackson, you mentioned the problem that Dr. Covington also commented about, and that was that the physicians were being left out of home health care in that there is a need to restructure.

If you were the administrator and we could just put you in the position of running the whole thing, what would you do? What changes in legislative authority would the administrator need to make in order to affect fundamental changes in our current home health care program?

Dr. JACKSON. Probably the first thing I would do, Senator, is have a hearing. In answer to this question, I have pretty much resigned myself really in terms of actually physicians and such that we pretty much have been dealt out.

And, very honestly, what I propose to you is that the individuals—they are special people. They have unique needs. And I think home health is going be around for a long time.

And since this is going to be the model, I would make a plea to go ahead and let us have nurse geriatric practitioners. In other words, these people who can basically go out to the home, assess the folks and so on, and pretty much handle the great majority of these situations. Then if they do get in difficulty or problems, then call the physicians such as myself or whatever here. In terms of financing how to do it and such, I am not even prepared to offer an answer.

Senator COCHRAN. Will there be a problem with State licensing laws by having a nurse geriatric practitioner actually there being on the front line of providing health care service?

Dr. JACKSON. I think it is like other things. As a matter of fact, I've talked with some of the folks from the State Board of Health and they recognize that they have got to change. Right now, for example, in nursing homes only physicians can make nursing home rounds in Mississippi. Many, many other states have already done away with that. I see this as just a very minor obstacle. Especially if it were——

Senator COCHRAN. Does the Mississippi State Medical Association have a policy on that at this time?

Dr. JACKSON. No, they don't. As a matter of fact, I'm chairman of that Council on Medical Services, and that has just never been discussed.

Senator COCHRAN. What would it take to make that change?

Dr. JACKSON. At what level? Are you talking about the State level?

Senator COCHRAN. Yes. Would it require State legislation?

Dr. JACKSON. I don't know whether it takes law or whether it perhaps is even region regulations. Joe, would you know? Honestly——

Senator COCHRAN. Mary raises her hand. Mary.

Ms. STAINTON. I raise a finger because I'm not fully informed. But this year in the hopper at the State Capital there is a bill for Medicaid reimbursement for nurse practitioners. So, somebody maybe in the audience could speak more to that. But there is something in the hopper this year for the first time.

Senator COCHRAN. You made some other comments that I thought were very helpful to our understanding of things that could be done to improve our response to these needs. And one is to form a geriatric team. You described that. That is at Forrest General Hospital in Hattiesburg.

Dr. JACKSON. Yes, sir.

Senator COCHRAN. You have this team based there. Are there others, to your knowledge, around this State following this model or are you the first to develop that?

Dr. JACKSON. To my knowledge we are the first. As a matter of fact, at the State Medical Association we are showing what we have done. This concept is not original with us. This is actually involved in academic concerns from across the country. I guess our uniqueness is the fact that we have taken a community hospital, we have taken earnest individuals, and we feel like we have put the glue together, and which we are making it work.

For example, we looked initially at people who were scheduled to go to nursing homes by the physician. By bringing this team together, we were actually able to get about 40 percent of them home.

Senator COCHRAN. That is very interesting. Well, I commend you for the work you do and the effort you make to try to identify ways to improve the system. And I think we need more people putting their minds to it like you have done and providing that information to us in this setting.

We want to stay in touch with you as these opportunities arise to make those changes so that we can have a continuing benefit or dialogue with the medical community as we do that.

Ms. STAINTON. May I tell you what question I'd like to answer?

Senator COCHRAN. Go ahead.

Ms. STAINTON. I've never been known for shyness. I'd like to go back to recruiting health care people. I'd like to feed off Cathy's remarks. She sparked some thoughts in my mind.

An interesting thing that we are having to jump through hoops to do this year is to certify our home health aides. And while I think this is an excellent program, we are supposed to have a plan in place in our companies, in our agencies, by February 14th, and totally implemented by August 14th which means all our aides have to be certified.

We have no guidelines; we have no national testing that said this is going to be it. I don't know if I can develop my own testing, do my own home health aides. So, these are some of the regulations we get from HCFA, but no guidelines.

And here we are supposed to be implementing something that I don't know what we are supposed to be implementing. And the State—when you talk with the State license and certification, they don't know either because they don't have guidelines. So, that is just a very minute frustration that we have to deal with in dealing with the bureaucracy regarding home care.

Senator COCHRAN. When is the deadline for completing the certification of home health aides?

Ms. STAINTON. August 14, 1990. But we had to have a plan, a written plan, for our company February 14, 1990. Which I have, but I don't know if it is going to fly. I don't even know if it is acceptable.

Senator COCHRAN. It may become the model nationwide.

Ms. STAINTON. It might be that. I'll send it to you.

Senator COCHRAN. Let's hope. Why don't you do that, and let me take it up with some of the people in Washington and ask them that question, you know, that you have asked me.

Ms. STAINTON. I'll do that. I'll do that. Very good. I'll do that.

Senator COCHRAN. A new person has just been nominated to be head of the Health Care Financing Administration, Gail Wilensky, Ph.D., and we are in touch with Dr. Wilensky.

We've also had an opportunity to have a hearing, as I mention earlier in this hearing, with Dr. Sullivan the other day. And we talked about some HCFA concerns and questions like promptness of reimbursement to providers. We brought that up with the Secretary. And I think we are going to see some more responsive action from HCFA on that issue and the new administration.

Ms. STAINTON. That is not unusual for us to get a mandate with no knowledge of how to implement it.

The other thing that I would like to speak to is the nursing shortage. There is a documented nursing shortage totally throughout the United States. We are seeing a current increase in enrollment in the curriculum year of 1990 which we have been very excited about. It has only been a 5.8 percent.

But the American Nurses Association is going on a very large ad campaign that is going to kick off March 1 that is really going to promote nursing as a profession. An interesting thing that is going to occur, is that then we are not going to have the schools of nursing prepared to hopefully take the influx of students that we see that will be coming.

And in just talking to USM School of Nursing last night, they are seeing an enrollment of about 25 percent increase in the fall of next year with lack of prepared faculty budgeted positions and clinical practice areas—or clinical experience areas for these students that will be coming through.

So, it is an interesting situation we are getting ourselves into. We have got a documented nursing shortage nationally, which makes recruiting very hard. And then you are going to get, hopefully, the influx of these students coming in and we are not going to be able to prepare them. So, that is something you might want to take back up to Washington and look at.

Senator COCHRAN. Well, right away I think of the fact that we do have some scholarship programs and some Federal funds that are available to help encourage, as incentives, those who would like to go into nursing schools.

Ms. STAINTON. See, we also need it for higher education for faculty preparation, too. That is beginning to be a documented shortage, too, for the Master prepared and Doctoral prepared nursing faculty. A serious consequence could come about on that.

The other thing that I'd like to say in home care, is something that has been—Dr. Jackson sparked my thought about it, is the specialty nurses that are required in home care now. Not only from the aspect of the geriatric prepared specialty nurse, but the oncology nurses because of the acute levels of the patients that we are getting.

Senator COCHRAN. Dr. Jackson.

Dr. JACKSON. If I might, again, I would like to, I think, reiterate the comments again that various others have made—that we need a continuum of actually being able to tailor the needs of the individual for the services available. Because at one time it may very well be just what I call case management—the aides and respite care, etc.

Other times you do need to go ahead and feed in the home health services. And right now, as was mentioned, home health care is actually for the acute situation. It is not for the chronic. And somehow we need some sort of central control where we can basically make this continuum easily accomplished for the individuals, for the caregivers, and such. It is simply not there now.

Senator COCHRAN. OK. Ms. Stainton, what is your last question that you would like to answer?

Ms. STAINTON. I can't think of one, Senator Cochran. Do you have one for me?

Senator COCHRAN. I was going to ask you about case management. What is the status of case management in Mississippi today? If nurses aren't doing it, who is doing it?

Ms. STAINTON. In the Home and Community Waiver Program—and Dr. Jackson is probably going to speak better to this than I am—there is a case management component of that. And I believe that is strictly social workers at this time. Is that correct, Dr. Jackson?

Dr. JACKSON. Yes.

Ms. STAINTON. That is primarily the only funded case management, isn't it?

Dr. JACKSON. Basically they do 100, I think, clients. Again, in Forrest County and Lafayette. There are really two others. For example, in Hattiesburg, as I understand, basically there is a waiting list of 25 or 30 people. And someone in the social work department said they have been unable to get anybody into the program for over 2 years.

Senator COCHRAN. I was interested in the comment Dr. Jackson made. I was going to ask Dr. Covington about it, the fact that we need to have almost an intermediate facility and concentrate some effort and energy on developing this as an alternative.

We've got nursing homes on one hand, and then a few retirement homes are being developed, and something called a personal care home was mentioned. I think Dr. Jackson mentioned that.

Do we see any movement toward that here in the Meridian area? I know there are some facilities being developed in Tupelo, the Jackson area, and Madison. Is this an answer? Maybe converting some of those hospitals that are now being closed or having a hard time making ends meet into some kind of resident facility that is in between what we now consider a nursing home for the comatose patient or the person who needs strict skilled care.

Dr. COVINGTON. We do have personal care beds in Meridian now, which a few years ago we didn't have. And I think it has been a big help. Of course, they are entirely private funded. There is no involvement of Medicaid, Medicare, and so forth, to help out people that are in lower income categories.

Senator COCHRAN. Should we explore amending some of our Federal reimbursement programs to encourage that kind of option?

Dr. COVINGTON. Yes, sir. That would seem appropriate to me. That should be looked into very carefully.

Senator COCHRAN. Dr. Jackson.

Dr. JACKSON. Again, I'm actually quoting what other States are doing. This is a so-called adult foster home. This is another concept, again, where you have not quite a personal care home but where, basically, you can have nonrelated individuals living within a home. This has been—there is also, I think, another concept that we can and should do in this State.

Another thing that I sometimes have seen is these people on Medicaid or whatever, and rather than paying $1,000 to the nursing home and putting them there, I would almost like to see a program where we could, say, give the family members 3 or $400 a month to go ahead and keep and care for them at home, and go ahead and utilize the ancillary services. It would be very cost effective, because you are keeping them out of the home. To me the nursing home is the last resort.

Senator COCHRAN. Ms. Stainton.

Ms. STAINTON. Just in closing I would like to share a personal experience regarding a personal care situation. My in-laws of 63 years, my father-in-law was terminally diagnosed last spring and died in October. And they lived--they were still in their home until three weeks before he died.

It had got to the point where that just was no longer acceptable. So, we moved him into a retirement home in Jackson. And in this retirement home apartment—they had some personal care apartments. And we were successful putting him there in the personal care apartments.

And they had LPN's and some aides that came around and bathed him. And with Home Health Agency coming in, we successfully kept those two people together. That was our goal was not separating them by putting him in a nursing home. And he died there in his own bed at 7:30 one night with his wife beside him.

So, it was, of course, privately funded, but it was very successful. I was pleased that we were able to keep him. And we could not have, if it had not been for the personal care situation.

Senator COCHRAN. I think we do need to emphasize these options. And I'm hoping that we can see an expansion of these services and of a wide range of services that are available to our older population here in Mississippi. We are going to continue to work in that effort.

To involve physicians more, Dr. Covington, I wanted to ask you specifically, in restructuring current home health care services, do you have a suggestion about how we could involve physicians more in the restructured program?

Dr. Covington. Well, first we need to be asked through organized medical——

Senator Cochran. I'm asking.

Dr. Covington. Yes, sir. On the payment thing, I hate to beat that to death. But I don't think it ought to be a bonanza to us, but now it is practically nothing. And it looks like that Medicare could provide a service code number for the service——

Senator Cochran. For physician's services.

Dr. Covington.—verlooking the care of a person.

Senator Cochran. When you are called and asked for advice, for example, and you——

Dr. Covington. This wouldn't have to be very large. I'm not talking about $100; $5 or $10, maybe. But something. At least then it would be appropriate.

Senator Cochran. In the written statement, just to show you that we did look at it, you mentioned something about chronically ill being over medicated and that being a problem. And I think that is something——

Dr. Covington. Yes, sir. That is one thing we have talked about in our Long-term Health Care Committee—that people need medication sometimes, but as they get older they don't need it as much. Their blood pressure doesn't run as high, or they don't have as much pain. Some medications are not very effective anyway.

One thing I was surprised is the Federal Drug Administration hasn't been a little bit more outspoken in trying to publicize the fact that some medications that we widely use are really not very effective. And some have been proved to be pretty much noneffective that are still on the market.

Senator Cochran. And are some that are used in combination with others even dangerous?

Dr. Covington. Yes, sir. And there are many dangerous combinations, exactly. And, of course, this is something we are trying to be more alerted to. But I think agencies probably should enter the picture, too, which they are certainly doing in the nursing home field through HCFA. When this first came out, I sort of objected to it. I thought they were trying to tell me what to do.

Senator Cochran. The guidelines for treatment medications?

Dr. Covington. The guidelines for use of medications. And I will have to admit that the more I think about it, the more I realize that they were proper in pushing us to prescribe less. That would be an additional cost savings and a plus in Medicare for the patient.

Senator Cochran. Everybody has personal experiences they can think about. But I'm thinking about my parents now who both are, I'm very happy to say, still alive and well, and at home. They sure are having to spend a lot of money on medication. It is becoming almost ridiculous the amount of money each year, when you add up the total annual cost for drugs. And they are not sick, you know.

You wouldn't think of them as being sick. People ask me how are your mother and daddy doing? Well, they are doing great, you know. But they just spent $5,000 on drugs last year.

Dr. Jackson. And perhaps they can pay that. I sometimes have people that have so many illnesses and so much medicine, that by the time I get through I really ask myself are they going to buy medicines or are they going to buy food. It really is to that point far more often than we sometimes like to think.

Senator **Cochran**. Well, that is an aspect of home health care that I think maybe we ought to spend some more time on. I don't know that we have time today to fully explore that. But it was in Dr. Covington's statement, and it caught my attention. I kind of agree with you. I think we are overdoing the drug business today. A lot of elderly are being taken advantage of maybe.

Well, we will look at that another day. I'd like to get into it right now, but we probably shouldn't. You all have been great. This has been a fine panel. Thank you very much for being a part of our efforts today.

Thank you so much.

Senator **Cochran**. Before I call the last panel to testify, let me point out that this is a subject where a lot of people have a lot of strongly held views and opinions. And if any of you are moved to share those views or opinions or suggestions with the committee, I invite you to do that. But because we don't have the opportunity to have everybody testify orally before the committee in this kind of setting, we would hope that you would provide us with your opinions in writing.

If you would like to submit comments or statements or suggestions on any subject that you think we should consider or have in our hearing record, I invite you to do that. We are going to keep our record open for a period of two or three weeks at least. Please write to me and send your statement to me, Senator Thad Cochran, U.S. Senate, Washington DC We will receive it, and we will make it a part of the hearing record. So, I hope you will feel free to do that.

Our final panel of witnesses today includes Federal agency officials. Mr. John Diaz, who is the Regional Program Director of Region VI, Administration on Aging in Dallas, TX is here; as is Mr. Ronald Niswander, who is deputy regional Administrator of Region IV of HCFA, Health Care Financing Administration, Atlanta, GA.

We are very happy that you are here with us today. We appreciate you joining us. You have had an opportunity to hear witnesses and to hear their testimony. And I hope you will make a part of your statement some comments, if you care to, on some of the issues that may have been raised during the course of the hearing.

We will begin with Mr. Diaz. You may proceed.

STATEMENTS OF JOHN DIAZ, REGIONAL PROGRAM DIRECTOR, REGION VI, ADMINISTRATION ON AGING, DALLAS, TX; AND RONALD NISWANDER, DEPUTY REGIONAL ADMINISTRATOR, REGION VI, HEALTH CARE FINANCING ADMINISTRATION, ATLANTA, GA

Mr. **Diaz**. Thank you, Senator Cochran, for the opportunity to appear before you today. Home health care is an issue that is extremely critical in the present and futures lives of older Americans, particularly for those who are frail.

Our commissioner designate, Dr. Joyce Berry, asked me to be here today to present this testimony. I'm going to just summarize it because I think we have given you a copy of it. So, I will just quickly go through that.

Several sections of the Older Americans Act, as you know, include home health services among the services which are to be supported by Title III resources. Part D of Title III, as you recall, includes home health services within the definition of in-home services and was funded in the amount of 5 million 700-plus thousand dollars for this fiscal year.

AOA has consistently emphasized the concept of maintaining the dignity and independence of older persons for as long as possible. And it seems to me that what we have heard this morning is certainly the kind of trend that everyone seems to be supporting for sure.

Several factors, we feel, are contributing to the trends in home health services, however, which strongly influence the need for, and the provision for, home health services including demographics, longevity, in-home service developments, and the emergence of potential alternatives to institutionalization.

Demographics, for the most part, you have heard so I will skip over that, if I may, sir.

Longevity, past and projected life expectancy at birth has increased from 61.4 years in 1940 for males to 76.8 in 2060, and from 67.7—65.7 for females in 1940 to 83.6 in 2060.

Emphasizing—the emphasis on in-home services, recent amendments to the Older Americans Act reflects a stronger interest on the part of Congress in the development of community based services designed to meet the needs of disabled, elderly persons. Also, a steady increase in the number of home-delivered meals is occurring nationally in our program.

In our region, for example, about half of the home delivered meals—or half of our meals are home-delivered meals. And in Mississippi of the 3,200,000 meals, over half are home delivered. So, there is quite a trend here. The number of Medicare certified home health agencies has increased 43 percent between 1983 and 1989 from 4,257 to over 6,085 respective.

Also, with the emergence of potential alternatives, many practitioners and researchers have taken the position that home health services alone are not a deterrent to institutionalization. I think we have heard that quite a bit this morning. Factors that could delay or deter institutionalization would include whether the dependent, older person lives with a spouse or family, the availability of informal support, and the availability of in-home services such as home-delivered meals, respite care service, chore services, and transportation services.

An increasingly important administrative community based function is the availability of case management to elderly clients and their families. We have heard a lot about case management this morning, but it can play a vital role in assisting the elderly, particularly the frail, in assessing—accessing the appropriate services and quality needed.

In many cases part of the case management function relates to pre-screening to determine collaboratively with older clients whether the community based or institutional care services are the preferred choice.

According to a GAO report, November of 1988—it is called "Long-term Care for the Elderly: Issues of Need Access and Cost"—80 percent of the dependent elderly live at homes in the community. And the majority of those are women, about two to one to men.

AOA goals for home health services have been developed. We are keenly aware of the many dynamics converging to create an increased demand for home health services and the national challenge to meet these demands.

Following a developmental process which has been characterized by continued dialogue with advocacy groups in the field—including State directors, area agency directors, academic and others—AOA has developed eight goals nationally which have been submitted to Congress. I'll just quickly list what those are.

The first one is public/private partnerships; second, older persons as a resource, using them and recognizing their efforts in that area; strengthening the family and generational bonding; fourth, prevention and alternative to institutional care; fifth, promotion and enhancement of effective community based service systems; and then targeting the resources we have very statically. With regard to manpower development, one of the earlier panelists talked about the need in that area and increased awareness of and promote the action to relieve the critical manpower needs in the field of aging with particular attention to the need for an adequate supply of trained personnel to care for older persons at home, in the community, and in nursing homes.

Incidentally, as you know, Senator Cochran, two of the recent funding decisions AOA made relevant to this goal involved institutions of learning in your home State. Tougaloo College in Tougaloo, Mississippi, received $60,000 to establish the training program or in-service and pre-service health personnel and public and private health agencies. And then Alcorn State University at Natchez received $60,000 to design, demonstrate, and evaluate a model that uses practical knowledge to improve health behavior of minority elderly in southeast Mississippi.

The last goal relates to preparing for the 21st Century, challenges and opportunities for an aging society.

In conclusion, the Administration on Aging recognizes that, even beyond the many specific actions which are required to achieve the eight goals outlined above, more needs to be done in the areas of policy decisions and program activities to insure the well-being of the nation's older persons during the last decade of this century and the initial decades in the next century.

Senator Cochran, this concludes my testimony. On behalf of our Commissioner-Designate, Dr. Joyce Berry, and the Administration on Aging, you are to be commended for your interest in issues of cardinal importance to older people of Mississippi and to the Nation.

Thank you, sir.

[The prepared statement of Mr. Diaz follows:]

PREPARED STATEMENT OF JOHN DIAZ

INTRODUCTION

Thank you, Senator Cochran, for the opportunity of appearing before you today at this very important hearing. Home health care is an issue that is extremely critical in the present and future lives of Older Americans, particularly for those who are frail.

I am John Diaz, Regional Program Director for the Administration on Aging (AoA) in U.S Department of Health and Human Services, Region VI. I've been asked by Dr. Joyce Berry to represent the Administration on Aging here today.

As a quick overview, the Older Americans Act (OAA) of 1965 established the Administration on Aging under the Department of Health and Human Services and authorized grants to a national network of 59 State and over 660 area agencies on aging. The agencies serve as the focal points for community-based, OAA-funded services.

THE OLDER AMERICANS ACT: SUPPORT FOR HOME HEALTH SERVICES

Several sections of the Older Americans Act include home health services among the services which are to be supported by Title III resources; for example, Section 306 (a)(2) includes language requiring that an adequate proportion of Title III dollars be used for home health under the rubric of in-home services. Part D of Title III includes home health services within the definition of "in-home services" funded separately in the amount of $5,756,414 for fiscal year 1990.

AoA has consistently emphasized the concept of maintaining the dignity and independence of older persons for as long as possible. Home health services continue to play a vital role in helping older individuals maintain their independence and dignity. We believe that the importance of these services will increase in the future.

TRENDS IN HOME HEALTH SERVICES

Several factors strongly influence trends towards the increased need for, and provision of, home health services: demographics, longevity, in-home service developments, and the emergence of potential alternatives to institutionalization. I will next summarize key developments and trends affecting each of these factors.

- Demographics
  - The elderly population is growing older. In 1988, 41 percent of the elderly population was 75 and older. By the year 2000, nearly half of the elderly population is projected to be 75-plus. (Bureau of Census)
  - The 85-plus population is growing especially rapidly. This population group is expected to be seven times as large by the middle of the next century as it was in 1980. (Bureau of Census)
  - 15% of those 65-69 reported difficulty with one or more activities of daily living (ADLs) in contrast to 49% for people 85 years or older. ADLs include bathing, dressing, eating, getting in and out of bed and chairs, walking, going outside and using the toilet. (National Center for Health Statistics 1987)

- Longevity
  - Past and projected life expectancy at birth has increased from 61.4 for males in 1940 to 76.8 in 2060, and from 65.7 for females in 1940 to 83.6 in 2060.

- In 1940, life expectancy for males at age 65 was 11.9 years; male life expectancy is projected to increase to 17.8 additional years by 2060. For females, life expectancy at 65 was 13.4 years in 1940 projected to 22.2 years by 2060. (Social Security Adminstration, 1989)

. Emerging Emphasis on In-home Services

- Recent amendments to the Older Americans Act reflect a stronger interest on the part of Congress in the development of community-based services designed to meet the needs of disabled elderly persons. Title III, Part D, In-Home Services for Frail Older Individuals, which was mentioned earlier, was added to the Act by the 1987 Amendments.

- A steady increase in the number of home-delivered meals is occurring nationally. Of the total number of meals served among the five States in Region VI, almost half were home-delivered meals. In Mississippi, of the 3,200,000 meals served in 1989, 1,500,000 were congregate and 1,700,000 were home-delivered. Indications are that a strong emphasis in serving the homebound elderly exists in Mississippi. As these trends continue to increase, so will the demand for home health services.

- The number of Medicare certified home health agencies has increased about 43 percent between 1983 and 1989, from 4,257 to 6,085 respectively.

Emergence of Potential Alternatives

- Many practitioners and researchers have taken the position that home health services alone are not a deterrent to institutionalization. Factors that could delay or deter institutionalization would include whether the dependent older person lives with a spouse or family; the availability of informal supports; and the availability of in-home services such as home-delivered meals, respite care, chore services, and transportation services. An increasingly important administrative community-based function is the availability of case management to elderly clients and their families. Case management can play a vital role in assisting the elderly, particularly the frail, in accessing the appropriate services in the quantity needed. In many cases, part of the case management function relates to a pre-screening to determine, collaboratively with the older client, whether community-based or institutional care services are the preferred choice.

As pressures for in-home, community-based services have increased some State and Area Agencies have exerted strong efforts to develop alternative resources such as additional State appropriations, collaboration with Medicaid, client cost-sharing arrangements and strengthening coordination and collaboration with the private sector.

According to a GAO November 1988 report, Long Term Care for the Elderly: "Issues of Need Access and Cost", in 1985 80 percent of the dependent elderly lived at home in the community. The majority were women, about two to one to men. 3.4 to 3.5 million had one or more ADL dependencies and an estimated 621,000 to 995,000 were severely disabled with five or more ADL dependencies. The report indicates that "the long term care population is expected to increase from an estimated 6.2 to 6.5 million in 1985 to approximately 14.3 million by 2020. The most rapidly growing segment of the disabled elderly in the community is the very dependent--those with five or more ADL dependencies."

AOA GOALS AND HOME HEALTH SERVICES

The Administration on Aging is keenly aware of the many dynamics converging to create an increased demand for home health services and the national challenge to meet such demands. In the 1987 Amendments to the Older Americans Act, AoA was directed to publish annual agency goals. It is altogether fitting and appropriate that, as we approach the last decade of the 1990s and the Silver Anniversary of the Older Americans Act, we begin to expand our goal efforts and begin preparing our society to address policy issues which will certainly carry over through the 1990s and beyond, into the 21st Century. It is important that our society becomes focused on the need to build adequate capacity to respond to the dramatic increases in the older population during the next century.

Following a developmental process which has been characterized by continued dialogue with advocacy and interest groups in the field of aging, including discussions with State Directors on Aging, Area Agency Directors, service providers, the academic community, the Federal Council on Aging and representatives of the Leadership Council of Aging Organizations, the Administration on Aging has selected eight areas of major activity in which goals have been established for Fiscal Year 1990 and beyond:

1. Public/Private Partnerships - Increase awareness within both the public and private sectors of the challenge of the changing demographics, and stimulate the expansion of services and resources for older persons by promoting public/private sector partnerships.

2. Older Persons as a Resource - Promote the recognition of older persons as a resource to themselves, to their community, and to the nation.

3. Strengthening the Family and Generational Bonding - Increase understanding of the societal implications of aging, with particular attention to the development and implementation of strategies for strengthening the family and the interdependence of generations.

4. Prevention and Alternatives to Institutional Care - Promote the recognition of the importance and the development of preventive, in-home and community-based supportive services as vital components of the continuum of care.

5. Promotion and Enhancement of Effective Community Based Service Systems
   Promote and support the continued strengthening of comprehensive and coordinated community service systems to insure that such services are available, accessible, and acceptable to older persons.

6. Targeting - Strategic Resource Allocation - Develop and implement new strategies for more effectively targeting resources and programs on the needs of the most vulnerable older persons, with special emphasis on low-income minority elderly.

7. Manpower Development - Increase awareness of, and promote action to relieve the critical manpower needs in the field of aging, with particular attention to the need for an adequate supply of trained personnel to care for older persons at home, in the community and in nursing homes.

   Incidentally, as you know, Senator Cochran, two of the recent funding decisions AoA made, relevant to this goal, involved institutions of higher learning in your home State:

   - Tougaloo College, Tougaloo, Mississippi, for $60,000 to establish a training program for in-service and pre-service health personnel in public and private health agencies.

   - Alcorn State University, Natchez, Mississippi, for $60,000 to design, demonstrate and evaluate a model that uses practical knowledge to improve health behavior of minority elderly in southeast Mississippi.

8. Preparing for the 21st Century- Challenges and Opportunities of an Aging Society. - Promote public information and technical assistance to targetted groups for better decisions which need to be made now to insure that public, voluntary and private sector organizations are responsive to the resources and needs presented by the increasing numbers of older persons during the first decades of the 21st century.

CONCLUSION

The Administration on Aging recognizes that, even beyond the many specific actions which are required to achieve the eight goals outlined above, more needs to be done in the areas of policy decisions and program activities to assure the well-being of the nation's older persons during the last decade of this century and the initial decades of the next century. Nevertheless, we believe that the agenda, which these eight goals establish, comprises a realistic projection of what, working together, the Administration on Aging and the field of aging can begin to accomplish. Our overall mission remains what it has been all along - to make life better for the millions of older persons whom we serve. We are committed and dedicated to making a difference on behalf of older persons. In this we need the help of all concerned citizens in the public, private and voluntary sectors across the nation.

Senator Cochran, this concludes my testimony. On behalf of our Commissioner-Designate, Dr. Joyce Berry, and the Administration on Aging, you are to be commended for your interest in issues of cardinal importance to the older people of Mississippi and to the nation. Thank you, Sir.

Senator COCHRAN. Thank you, Mr. Diaz, for your helpful comments and for your remarks. I appreciate that very much, and appreciate Dr. Berry and her support that she gives our efforts in this very important issue area.

Mr. Niswander, thank you very much for being here. I know you don't have a prepared statement. We asked you to be a resource person to sort of help us evaluate some of the issues that were raised and make whatever comments you would like to at this time. Thank you for being here.

Mr. NISWANDER. Thank you, Senator. I appreciate it very much. I might mention, also, that we are very pleased with the new administrator, Dr. Gail Wilensky, who is really taking hold and understands the problems that are inherent in the health care system. And we really feel pleased that she is on board as the HCFA administrator.

For those here who may not have a full appreciation of the Health Care Financing Administration, I might spend just a moment or two to indicate what that agency does. We, of course, administer the Medicare and the Medicaid program, directly administer Medicare as a Federally administered program and work with the State agencies, State Medicaid agencies, to provide principal funding and general direction for the administration of the Medicaid program.

The Medicare program has very set prescribed coverages, payment mechanisms, etc; where under Medicaid there is a great deal of flexibility within the State as to how they administer and operate the Medicaid programs. That is the substantial difference between the two.

And we look at those two programs as, perhaps, the basic funding areas for many of the health care needs of the people we are talking about today, that we need to keep in mind the differences between the programs and the nuances that exist in terms what might be done through the different programs.

It was mentioned earlier that home health was really a sleeper when Medicare was first passed and implemented. It is really not a sleeper any more. Since 1981 the payments for home health services have trippled to $2.5 billion in 1989. And in Mississippi specifically, Medicare paid $55,462,000; and in 1989, $66,052,000. And under Medicaid, which is a much smaller program as far as home health services is concerned, the payments were $4,751,000.

It continues to grow. We now have 78 certified home health agencies in the State of Mississippi. The Health Care Finance Administration is also responsible for surveying and certifying nursing homes and home health agencies, laboratories, etc, in the State.

So, we are very much involved with the quality of care that is provided by nursing homes and home health agencies in the State of Mississippi working closely with the State Health Department, and the State Medicaid agency.

There is a great deal of emphasis being put on the utilization of the Medicaid State waiver program for reaching these individuals who are, perhaps, falling through the cracks or who may be better served in their home rather than in the nursing home. As we discussed this morning, Mississippi has one home and community based waiver program under way. We are reviewing that in terms of extending it. To the best of my knowledge, we do not foresee any problems in getting that waiver program extended.

I think what bothers or is a potential problem to a lot of the States—and many States have these waiver programs under way—the intent was to not only find a way to better serve the recipients at home and free up some nursing home beds, but to look at it also as a cost-saving measure.

It seems that when a State implements a waiver program covering 500 patients, these patients are those who would have required nursing home care. They are being taken care of in the home under the waiver program. Those 500 beds in the nursing homes continue to fill up with Medicaid patients.

So, it is really not—it seems that there is a bottomless reservoir out there of Medicaid elderly or elderly who can qualify for Medicaid to fill every nursing home bed that can be built. So, that is a major problem facing the states and State Medicaid programs.

A lot of—a major concern also by the State Medicaid agencies is how to divide up the resources available to the State Medicaid program. Maybe I could spend just a moment on the funding mechanism for Medicaid. Medicaid determines what is to be included in the State Medicaid program. There is budget, a State budget, for that program which is matched by the Federal government. The matching rate depends on the per capita income within the State. And in Mississippi the Federal matching rate is about 78 percent, between 78 and 79 percent, I believe.

The concern in a lot of states is how to spread this shortage of money, really, because Medicaid has really taken over a lot of State budgets across the country. It is almost becoming a critical situation.

How do you parcel out the money to where you provide the needs for the mothers and the infants who are on Medicaid in an effort to reduce the infant mortality rate in this country which is—which ranks about 19th in the industrialized world? How do you balance that against the needs of the elderly whose needs are just as critical as the needs of the infants and the mothers?

So, these are some of the problems that the states are facing. As you know, it has been dealt with by many, many groups and the Congress and Administration and many other entities across the country. I don't know the answer. I'm here to carry out the policy that comes from these conclusions.

Senator **Cochran**. You are very kind to be here, and I appreciate your contribution to the hearing. You heard one of the suggestions that we have a coordinated approach to the delivery of health care for older citizens. The geriatric team approach was mentioned specifically that is a model program in Hattiesburg at their general hospital there.

What is your reaction, specifically, to the need around the country or around our State for more of a coordinated approach involving specially trained geriatric professionals in providing services to older citizens?

Mr. **Niswander**. I am a firm believer that there has to be extreme coordination in providing health care to these individuals. It is a situation that has gotten to the point where each government entity cannot go its own way and get the job done. There has to be very much a coordinated effort.

I know in most of the States where there are home and community based waivers, those waivers have probably done more to bring the Aging Agency in the State, the Medicaid Agency, the Welfare Agency, and others involved together than perhaps anything else in the history of Medicaid.

And I think it has got to be that way. And the way it is brought about certainly varies from State to State. But it has to be a primary emphasis and priority for success in this area.

Senator COCHRAN. Do you find that it is a problem when you require the skilled care as a means for getting access to program reimbursement that we ought to abandon the fiction in some cases and provide reimbursement directly for custodial care that does not reach the level of requiring skilled or professional care?

Mr. NISWANDER. Well, that is certain something that would have to be dealt with nationally. That is your level because Medicare, as it is now constituted, is a health care program. And that doesn't really include custodial care.

On the Medicaid side there is flexibility within the State. Under Medicaid, the states must provide certain mandatory services, hospitals, nursing home care, home health care, etc. But there are optional services that a State can include in their program. And some of these services get closer to custodial care—nurse aide care, personal care services, etc. These are optional services.

And, quite frankly, only the most wealthy states generally include these services in the Medicaid program because most of the states are having enough trouble as it is keeping the current Medicaid program afloat. But it is a way. It is a possibility, and it is there if the State wants to take advantage it. If the State includes these services under the Medicaid program, then the Federal matching will be there.

Senator COCHRAN. Is it a 50/50 match; the Federal Government pays half the cost and the State comes up with the other? What is the share on those services?

Mr. NISWANDER. These are services which will be matched at the service matching rate, which is the rate that varies—depending on the per capita income in the State—that varies from 50/50 in wealthier States like New York, California, Ohio, Pennsylvania, etc, to the very poor States which can go up to 83 percent.

And, as I indicated, Mississippi can get about 78 to 79 percent matching for these services. There are services, manage-care type services, that could be included for target groups and be matched at the 50/50 administrative matching rates. There are also some manage-care services that could be considered a medical service and be matched at the higher matching rate.

Senator COCHRAN. I promised Ms. Stainton when she was testifying that I would take back to Washington a request for some guidelines or at least some guidance in the development of the certification plan for aides under the program for home health visitation. Would you do me the favor of carrying that back to Atlanta, too, to stir some minds to working about guidance for those who have to comply with those deadlines?

Mr. **Niswander**. I'll certainly do that. And we have two areas where this is a concern: The nurse aides for nursing homes, as well as the home health aides and the training for those individuals. I'll be happy to do that.

Senator **Cochran**. That would be very helpful, I'm sure, to her and all of those who are similarly situated, if you could do that. That would be very good.

Mr. Diaz, I noticed in the suggestions we have had before us in Washington people talking about a national health care policy. And I know that the Administration on Aging is interested in participating in the development of a national health care policy because the older citizens in our population are, in many instances, those who are the largest number of consumers of health care services in our country.

Do you feel that home health care services should be a key component or ingredient in the development of a national health policy?

Mr. **Diaz**. Personally, yes, sir. I think, for the most part, we have included that in some of the kinds of things we have recommended to the States in developing. Earlier I think there was a nurse, Ms. Lomax, who was talking about the continuum of care at the community level. And I think Dr. Jackson made mention of that, too.

As we look at the health care policy wondering whether it would be possible to convert so many of these various funding streams in such a way that an older person could, perhaps, access them through one point or to minimize the amount of or the number of places they might have to go to for their families, as the case might be. But it seems to us that with respect to the language that you put into the Older Americans Act about the role of area agencies in developing a comprehensive array of services, certainly health care and health related services are important to that.

The role of case management that was talked about here oftentimes this morning as an access point and the discussions that were made about the role of the medical profession in that we have certainly supported those kinds of efforts.

And we feel that that ought to be part of some kind of a policy in which is the multidisciplinary team of physicians, nurses—we don't want to leave out the social work and other components because we feel that, for the most part, if it has a heavy medical orientation, then there is a tendency to leave out some of the other services that could play a crucial part in maintaining an older person in their home.

But some of the models that we have funded—and Congress has certainly recognized those models such as in San Francisco where you have a multidisciplinary team of a physician, nurse practitioner, social worker, PTOT specialists, and others to look at the whole spectrum of service needs using—most of us—or those models are using the Older Americans Resource Survey. We've used them in some of the models in our region, some of the hospitals with the Robert Wood Johnson Foundation funding have used those kinds of approaches as well.

And they seem to be very effective in addressing the needs of frail, elderly people. Because I don't know that they just stay in one condition. They seem to keep—they seem to fluctuate. Their

AD alimentations are maybe 2 today, could be 3 tomorrow, and then back to down to 2. It is never just a static situation.

And the question is whether we can design some kind of a system in which it addresses those needs on a chronic basis as well as an acute care basis. I think that is where we have been somewhat frustrated. And I fail to see how we could put that kind of a system in place.

Senator COCHRAN. What does the ADL acronym stand for?

Mr. DIAZ. Activities of daily living.

Senator COCHRAN. Pardon?

Mr. DIAZ. Activities of daily living. They relate to dressing, bathing, eating, etc.

Senator COCHRAN. One thing that we had mentioned here earlier was the emphasis on preventing illness and disease and trying to keep people healthier through better nutrition and diet and avoiding things like smoking cigarettes and abusing drugs and alcohol and the like.

Do you see the social service aspect of all of this as being a necessary ingredient of a preventive health program for older citizens and how does the Administration on Aging see itself contributing to the effort to be more aligned with the focus on preventive health care?

Mr. DIAZ. Well, that is one of our eight goals, Senator. And over the last few years we have been working very closely with the public health service precisely to that end. The Surgeon General had a workshop on health care needs of the elderly about two years ago in Washington, DC There were various panels dealing with issues—smoking cessation, proper drug utilization, nutrition education, physical fitness. There are four or five others that were included in that.

But we now have, and have had for some time, the strategy with public health to launch health promotion for the elderly. And, also, in conjunction with the American Association of Retired Persons, we have a national resource center that we funded at AARP, and they, in turn, are providing assistance to the states and the local levels to develop these kinds of efforts.

But we have been very—working closely with public health. We would like to see and have seen, to some extent, the use of community health centers as a way, also, to deliver that kind of an approach. Recently, we have funded some of the health science centers to develop films in those areas.

Yesterday, for example, we had reviewed some films dealing with a variety of areas developed by the University of Texas Health Science Center on preventive activities. We hope to show those in senior centers. We want to use them in hospitals, in waiting rooms, etc, but just anywhere we can reach older people or their families so that we can build with the whole issue of prevention. It is big, big size of this whole effort.

Senator COCHRAN. You have been very helpful and, Mr. Niswander, you as well, in helping to wrap up and refocus our attention on some of the national policies and programs that really are very important as we try to deal with these challenges in the health care area for older citizens.

I think all of our panels have really been very important contributors to the dialogue we have had here today and to the hearing record that we will carry back with us to Washington. And all of you have been very gracious and helpful in being here. And I want to thank you.

I also want to thank my staff members, who have been here from the offices in Mississippi, as well as the Washington offices. Our staff director of this subcommittee, who is from Bogue Chitto, MS, is James Lofton. He is in the back of the room. He is the person who is actually the lead staff member in Washington over this issue area for our subcommittee. And I'm glad that he was here and also that he was able to contribute his leadership to this hearing effort today.

Linda Roach has been sitting here at the table with me all day, and she is a Mississippian who is member of my staff in Washington as our legislative assistant who specialized in health care areas, among other things. But she is very important to our effort to make sure that Mississippi's interests are taken into account as the Congress legislates in matters affecting the health care industry and citizens who are interested in those issues.

We also have had good assistance from Lee Sanders, who is not here today. She is in Washington. But she is a member of our staff at the Aging Subcommittee. Janice Mitchell, who is from our Mississippi office, is here. And we appreciate her being here. She works in the Jackson office and helps deal with problems that individual constituents have with Federal agencies who are involved in health care matters.

Lynn Moten who is here from our Washington staff has been very helpful in arranging and dealing with some of the coverage of our program here today. Wiley Carter, my administrative assistant, has also been here with us for this hearing. And I appreciate the help that all of them have given to this effort. I also want to thank Peggy Klepzig, who has been our court reporter present recording everything that you-all have said, and will help put together the hearing record so that there will be a continuing information base as we legislate on these and other areas in Washington.

I have been asked to tell you-all, also, that the hearing has been covered by Comcast Cable, who have had a gavel-to-gavel coverage of this hearing and to remind everyone that this will be aired tonight on Comcast Cable. So, a commercial break there to keep the wheels turning.

You-all have been very helpful who have been here to participate as spectators and observers. And I do want to invite you, again, to contribute your suggestions or comments to our hearing record by simply writing me a letter which we will include in the record or enclosing a more formal statement, if you would like to do that, in our hearing record.

[An additional statement submitted for the record follows:]

PREPARED STATEMENT OF THE STATEWIDE HEALTHCARE SERVICES, INC.
PATRICK F. YARBOROUGH, PRESIDENT

Senator Cochran, I commend you for your interest in the elderly and the roles that in-home services can play in their lives. My name is Pat Yarborough and I am the owner of two agencies which provide at-home services in Mississippi and Alabama. My two agencies are licensed by Upjohn HealthCare Services, the nation's largest provider of at-home services. I was reared and educated in Columbus, Mississippi, and graduated from Mississippi State University. Since 1973 when I opened the first for-profit provider of at-home services in Mississippi, my agencies have delivered a wide variety of at-home services - including intensive round-the-clock nursing care; Homemakers and Respite services; Medicare/Medicaid-funded home health services; Home Health Aide Services; and Live-in Companion services.

Receiving services at home has proved to be a cost-effective and consumer-preferred alternative to institutionalization. Unfortunately for the elderly, in-home services has also been at times a confusing, fragmented, ill-defined, partial solution to their needs. Even today's more-sophisticated elderly consumer is often unaware of the options available for receiving assistance at home. In Mississippi there are at least three very-different types of at-home services:

Home Health Agency Services

Medicare-funded home health care is acute-care oriented. The model for service-delivery is based on part-time, intermittent visits by licensed nurses, home health aides, medical social workers and specific types of therapists. Providers must be certified by Medicare as a home health agency and must meet the standard Conditions of Participation to remain in the Medicare program. Provider paperwork requirements are extensive. (This may produce the effect of the Provider focusing on meeting the needs of the program, rather than the needs of the consumer). Medicare reimbursement is based on each agency's actual costs per visit. Medicaid reimbursement for services by a certified home health agency is established by each state and is inconsistent nationally. Access to home health agency services is controlled by the existing health care community (primarily physicians), which has a bias toward institutional health care. Moreover, in many states, inappropriate state Certificate of Need laws restrict the consumer's choice of provider to only those organizations awarded a franchise by the state to be a home health agency. (This is a self-perpetuating problem because health-care-related state legislation is heavily influenced by the existing health care community.)

This lack of competition is particularly evident in Mississippi. Nationally, the number of home health agencies increased 43% between 1983 and 1989. During this same period of time, the number of home health agencies in Mississippi actually decreased. Moreover, in a 1983 listing of the 40 largest home health agencies in the nation, Mississippi had two of the largest (#11 and #13). Also, the largest home health agency in our State (the State Board of Health) controls the Certificate of Need process and therefore can directly restrict the number of competitors and the location of those competitors. Restricting competition is not in the best interest of the consumer. **Competition produces innovation, price-containment, consumer/physician education and quality commitments.** Most importantly, a January, 1986 Federal Trade Commission Report titled Certificate of Need Regulation of Entry into Home Health Care concludes that application of the certificate of need process to home health care agencies produces HIGHER COSTS.

Other At-home Health Care Services

There are a variety of at-home health care services delivered by agencies which may not be certified as home health agencies. The model for service delivery is usually on an hourly basis and may include licensed nurses, home health aides, and patient attendants. These services range from acute care under a physician's plan of treatment (i.e. around-the-clock private duty care by Registered Nurses of a terminally-ill cancer patient), to limited personal care (i.e. four hours of morning care by a patient attendant during which the patient is assisted with bathing, dental hygiene and grooming). Sources of payment are primarily private insurance and out-of-pocket private funds. Some states require agencies delivering private at-home services under physicians' orders to be licensed. Mississippi has no licensure law for private agencies. The exact volume of these services being delivered nationally is unknown because there are few regulation/accounting requirements imposed by the government on the agencies delivering them. Since a large percentage of these services are paid for privately, the agency can focus on meeting the true needs of the consumer instead of the requirements of a particular funding program. Access to services is open to anyone who can pay and who is aware of the availability of the services. Specialized health programs (hospice, IV therapy, renal dialysis, etc.) could also be placed into this category of services.

Independent Living Services

These services are not usually health care related and usually do not require physician or licensed nurse oversight. They include homemaker services, chore services, grocery shopping, transportation services, and respite services. The model for service delivery for homemaker, chore and respite services is hourly. Funding may be out-of-pocket, or by one of several government programs including Title 20 of the Social Security Act, the Older Americans Act and Medicaid (under the waiver program).

Government-funded independent living services in Mississippi are administered through the network of Area Agencies on Aging throughout the State - under a competitive bid process for each Mississippi county. There are Mississippi standards for service delivery for each type of government-funded program. Access to these government-funded services is normally through the Aging network throughout the State (especially through the Case Managers associated with the Aging programs in Mississippi). Several years ago, tax-paying (for-profit) agencies weren't permitted to deliver these services under government funds. Though this policy has changed, some people who administer these programs still have an anti-profit, anti-competitive attitude toward provider selection. An attitude of "a ministry, not a business" could limit competition and all of its benefits. **The competitive bid process has assured that the taxpayer is receiving the most hours for the monies available.**

Privately (out-of-pocket)-funded services are delivered by agencies who, again, can concentrate on meeting the needs of the Client, rather than the requirements of the funding source. Access is normally available to anyone who can pay and who is aware of the availability of the services.

Recommendations

With different service delivery models, different funding source requirements, and different primary access points, is it any wonder that the elderly consumer may be confused when we speak of home health care or in-home services? For the lower and middle income senior citizen, adequate private pay services at home are often too expensive - no matter how much they are needed. Home care is the consumer-preferred alternative to institutional care. **Home care is the definitive answer to the nation's long-term care dilemma.** For at-home services to be even more effective, I recommend:

1. Enact legislation to implement a long-term care plan based on home care

2. Establish national standards for each model of delivery of at-home services.

    - Recognize that each model needs different standards and that there is a greater need for consumer protection from technical incompetence in acute care delivery than in any other type of at-home services. Tailor the standards to require minimal paperwork in each model. The paperwork should be focused on assuring consumer protection and reimbursement integrity.

3. Encourage competition and extensive involvement of the private sector

    - Prevent all states from limiting the number of agencies delivering at-home services. Encourage states to remove state laws that limit the number of providers of in-home services by withholding Federal funds until such laws are removed. Permit all providers of at-home services to deliver the full range of services with full participation in all funding sources - as long as quality standards for each type of service are maintained.

    - Recognizing that demand for services will probably exceed supply, that training requirements will increase provider costs and that the marketplace should set provider prices; change the reimbursement approach under Medicare to an approach that will promote price containment by encouraging efficiencies of operation and by eliminating the expense of costs justification and the expense of costs audit. Standardize the reimbursement approach for home health agencies under all Medicaid programs using the new Medicare approach.

    - Help remove the health care industry's bias towards institutionalization by adequately compensating physicians for supervision of patients receiving home health services at home. This compensation should make their choice between at-home care and institutionalization more objective.

    - Assist in the elimination of any bias towards non-profit organizations in the Aging community by emphasizing the equality of all providers and by removing preferential tax treatment given to non-profit organizations which compete with for-profit organizations in the delivery of at-home services.

4. Establish ONE central contact point (phone number) in each community for information and case management.

 - Privatize the administration of this contact point. Use a competitive bid process to determine the recipient of each multi-year contract for the administration. A privatization approach will assure that the most innovative and effective methods of administration are developed and that those methods will be cost-effective. Government administrators of existing local health care programs and existing local social service programs will want control of this point because it may determine patient access to program services and case management. Unfortunately for the consumer, if the administrators of any existing programs, as a group, receive control of these contact points; they will have biases toward their existing service-delivery model, quality assurance approach, and reimbursement approach. An open, competitive bid process, involving the private sector, overcomes the turf-protection biases of existing administrators.

 - Give to the contact point the responsibility for quality assurance surveys of local providers (using Federal guidelines) and the requirement of publicizing the results of the surveys. Quality assurance of the administration of the contact point should be handled by the Federal government (through a competitive bid process nationally - again involving the private sector).

 - To further encourage competition, let the consumer - not the contact point's Case Manager nor the Physician nor the Provider - make the decision of which provider to use. Rely on the private sector (and competitive influences) to educate the consumer on considerations in choosing a provider. The contact point's personnel should make the results of quality assurance surveys easily available to the consumer to assist in his choice.

Again, Senator Cochran, I commend you for your interest. Thank you for letting me present these ideas.

Patrick F. Yarborough Phone (601) 982-7311
President
Statewide HealthCare Services, Inc.
d/b/a Upjohn HealthCare Services
3828 Interstate 55 North
Jackson, MS 39211-6324

Senator COCHRAN. Thank you-all for being here, and our hearing is now adjourned.

[Whereupon the hearing was concluded at 12:25 p.m.]

○